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Indianapolis, Indiana

# The JOURNAL



OF THE INDIANA STATE  
MEDICAL ASSOCIATION



1973

W.P. Loh, M.D.

SMA ANNUAL MEETING • October 6-11, 1973 • INDIANAPOLIS

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Everybody experiences psychic tension.



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Some people develop excessive psychic tension and need your counseling,



and a few may need counseling  
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Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

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Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect.

*Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.



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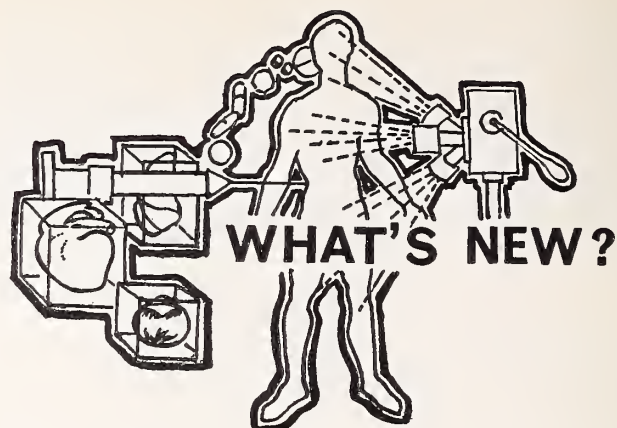
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Posey introduces an elbow sleeve of polyester fabric that is designed to minimize sheet burns. It may also be worn on the knees to prevent them from rubbing together or to keep them warm.

\* \* \*

Jamestown Products announces a new hydrotherapy tank for treatment of burns. It is a full body immersion unit which allows for motion exercises and burn and contaminated wound treatment technics. The unit was designed by Dr. George W. Lawn and is called the AVM-Lawn Hydrotherapy Station.

\* \* \*

Round sponges now have strings attached. Rondic® Sponges by Kendall come in both cotton filled and all gauze with two 18-inch blue cotton suture strands firmly attached to the sponge. All gauze edges are neatly tucked in and secured with a small x-ray detectable band.

\* \* \*

American Hospital Supply has the new American Clear Conductive Connective Tubes. Polyvinyl chloride tubing fitted with flexible HOLD-TITE funnel connectors to make a positive seal and cut in 6', 12' and 20' lengths. Comes in both sterile and nonsterile condition.

\* \* \*

The Pasadena Technology Press has published a 600-page book which discusses the use of plastics for general surgical procedures, implants and as components for artificial organs. "Handbook of Biomedical Plastics" is available at 55 dollars per copy, a price which is high for the casual reader, but is justified for anyone who is interested in artificial organs and sophisticated implants.

\* \* \*

Corning Glass announces the new Larc automatic blood differential system. The Larc analyzer and classifier system, slated for production by the end of the year, utilizes a computer-operated microscope in automatically locating and classifying six common white blood cell types. During the process the operator is able to view the sample slide microscopically to evaluate platelets and red blood cell morphology.

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.



an effective combination of medication  
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unique 10-grain buffered aspirin

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Each tablet contains aspirin, 600 mg. (10 grains); magnesium hydroxide, N.F., 150 mg.; aluminum hydroxide dried gel, 150 mg.

**Unique design.** In shape, size and color, CAMA looks like no other aspirin. It gives patients an "individualized" medication—one they may find more acceptable and possibly respond to more positively.

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**Adjustable dosage.** Scored tablet lets you increase or decrease dosage in 5 or 10 grain increments.

**Economical.** CAMA costs no more per dose than many 5-grain buffered aspirin tablets. Give your arthritic patients the added benefits of CAMA. Ask your Dorsey representative for a generous supply or write Director of Professional Relations.

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### EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

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Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

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Indexed in Hospital Literature Index.





The diabetic  
who has  
too much...

too much sugar,  
too much fat.

Maybe the last thing she needs is more of her own insulin. Especially when you consider that many overweight diabetics already have normal or high levels of endogenous insulin and that insulin is lipogenic.

If she just won't diet and oral therapy is indicated in adult-onset, nonketotic diabetes...

**DBI-TD<sup>®</sup> Geigy**  
phenformin HCl

lowers blood sugar without raising  
blood insulin.

For complete details, including dosage,  
please read the prescribing information.  
It's summarized below.

**DBI<sup>®</sup> phenformin HCl**  
tablets of 25 mg.  
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timed-Disintegration  
capsules of 50 and 100 mg.

**Indications:** Stable adult diabetes mellitus; sulfonylurea failures, primary and secondary; adjunct to insulin therapy of unstable diabetes mellitus.

**Contraindications:** Diabetes mellitus that can be regulated by diet alone; juvenile diabetes mellitus that is uncomplicated and well regulated on insulin; acute complications of diabetes mellitus (metabolic acidosis, coma, infection, gangrene); surgery or immediately after surgery where insulin is indispensable; severe hepatic disease; renal disease with uremia; cardiovascular collapse (shock); after disease states associated with hypoxemia.

**Warnings:** Use during pregnancy is to be avoided.

**Precautions:** 1. **Starvation Ketosis:** This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria which, in spite of rel-

atively normal blood and urine sugar, may result from excessive phenformin therapy, excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state. **Do not give insulin without first checking blood and urine sugar.**

2. **Lactic Acidosis:** This drug is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, periodic determinations of ketones in the blood and urine should be made in diabetics previously stabilized on phenformin, or phenformin and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH, and the lactate-pyruvate ratio. The drug should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis.

3. **Hypoglycemia:** Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.

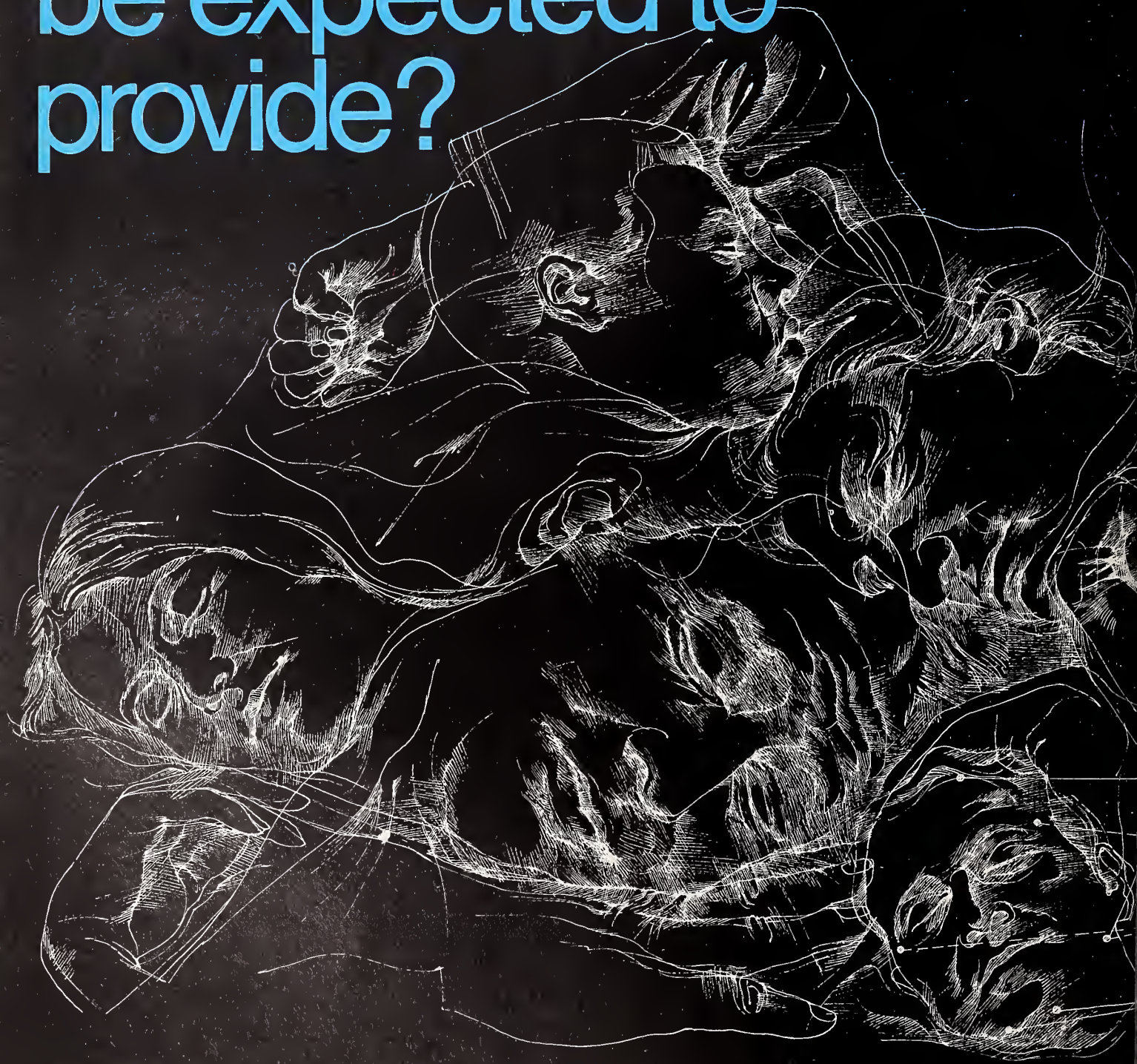
**Adverse Reactions:** Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake. (B) 98-146-103-E (6/72)

For complete details, including dosage, please see full prescribing information.

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Ardsley, New York 10502



# What should a medication for sleep be expected to provide?



**Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:**

**Indications:** Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or

recommended.

**Contraindications:** Known hypersensitivity to flurazepam HCl.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years

of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

**Precautions:** In elderly and debilitated patients, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with



## Sleep for 7 to 8 hours without need to repeat dosage during the night

No sleep medication has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia patients given one 30-mg capsule of Dalmane at bedtime, on average: fell asleep within 17 minutes, had fewer nighttime awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to repeat dosage during the night.

## Sleep with consistency

Dalmane has been shown to be consistently effective even during consecutive nights of administration. Thus there is little likelihood for the need to increase dosage to maintain therapeutic effect.

Dalmane (flurazepam HCl) is a distinctive sleep medication—a benzo-diazepine specifically indicated for insomnia. It is not a barbiturate or methaqualone, nor is it related chemically to any other available hypnotic.

## Sleep with relative safety

Chronic tolerance studies have confirmed the relative safety of Dalmane; no depression of cardiac or respiratory function was noted in patients administered recommended or higher doses for as long as 90 consecutive nights. Dalmane is generally well tolerated and morning "hang-over" is relatively infrequent. Dizziness, drowsiness, lightheadedness and the like have been the side effects noted most frequently, particularly in elderly and debilitated patients. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

# DALMANE<sup>®</sup>

(flurazepam HCl)

## When restful sleep is indicated

One 30-mg capsule *h.s.*—usual adult dosage

(15 mg may suffice in some patients).

One 15-mg capsule *h.s.*—initial dosage for elderly or debilitated patients.

ROCHE

ROCHE LABORATORIES  
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Nutley, New Jersey 07110

depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during prolonged therapy. Observe usual precautions in presence of impaired renal or hepatic function.

**Side Reactions:** Dizziness, drowsiness, lightheadedness, staggering, ataxia, falling have occurred, particularly in elderly or debilitated patients. Severe nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech,

Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech,

confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients.

*Elderly or debilitated patients:* 15 mg initially until response is determined.

**Supplied:** Capsules containing 15 mg or 30 mg flurazepam HCl.

# "Prescription drugs – who should determine the maker?"

## Dispenser of Medicine

Clifton J. Latiolais  
President  
American  
Pharmaceutical  
Association



## Maker of Medicine

C. Joseph Stetler  
President  
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Manufacturers  
Association



"Too many doctors are indifferent to the economic consequences of their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by former AMA Chief Executive F. J. L. Blasingame, M.D.

### Doctor, are you indifferent...?

In discussing an anticipated increase in Blue Shield rates, Dr. Blasingame's newsletter had this to say:

"In general, it can be said, MD's have given the impression they are not particularly concerned with the increase in cost of health care to their patients..."

"True, an MD's training is primarily scientific, but in the real world of practice, all of his scientific decisions have a price tag, or an economic impact. The economics of health care beckon the practitioner's attention. Concern for economics of medicine

When the pharmacist recommends that a drug product other than the one ordered be dispensed, the prescriber invariably permits the change when he feels the best interests of the patient will be served.

### Shortcomings of Pro-Substitution Argument

The fact remains that it is necessary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, the unilateral decision of the pharmacist, made in the absence of clinical knowledge of the patient, could expose him to needless risks, and in addition, jeopardize the relationship between the professions of Pharmacy and Medicine. In my view, there is nothing in the pro-substitution argument that offsets these risks.

### The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowledge about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degree, puts him at a disadvantage. Most often, a practicing physician will need expert knowledge of no more than 25



should be an obligation of medical practice...

"Medical societies ought to conduct continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in the patients' interest, question the tactics of any insurance organization that raises health care costs by forcing policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed to their patients for support in the fight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

### Cost of Drugs

Insurance rates and hospital charges are only two factors in health

care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists *are concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

### Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining

high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

### APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

*(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)*

or 30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with the particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substituting pharmacist may avoid even a technical breach of contract by simply notifying the patient that he is making the substitution. I would judge that few courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

### Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could follow legalization of substitution. We have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests

the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

### Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

### Summary

In short, what the American Pharmaceutical Association advo-

cates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

*(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)*

Pharmaceutical  
Manufacturers Association  
1155 Fifteenth Street, N.W.  
Washington, D.C. 20005





# THE INDIANA STATE MEDICAL ASSOCIATION

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Terms expire December 31, 1974:

Delegates	Alternates
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1.	William Dye, Oakland City	Martin J. Bender, Evansville	
2.		J. S. Brown, Carlisle	
3.	Claude J. Meyer, Jeffersonville	Robert K. McKechnie, Jeffersonville	September 26, 1973, Clarksville
4.	Joe M. Black, Seymour	John W. Ripley, Seymour	Seymour
5.	J. Franklin Swain, Rockville	Antolin M. Montecillo, Clinton	
6.	James H. Tower, Jr., Shelbyville	Arlington M. Hudson, Connersville	Connersville
7.	Eric Clark, Plainfield	M. O. Scamahorn, Pittsboro	
8.	David Dietz, Muncie	Arthur Jay, Muncie	Aug. 29, 1973, Muncie
9.	Lowell R. Stephens, Covington	Theodore C. Person, Veedersburg	June 14, 1973, Attica
10.	Lambro Dimitroff, Hammond	Mario D. Mansueto, Munster	Sept. 5, 1973, Valparaiso
11.	Joseph S. Bean, Logansport	Fred Poehler, La Fontaine	Oct. 3, 1973, Marion
12.	George C. Manning, Fort Wayne	William B. Hughes, Waterloo	Sept. 13, 1973, Fort Wayne
13.	James Rimel, Plymouth	David L. Spalding, Mishawaka	Sept. 12, 1973, Plymouth



This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the first of each month preceding month of issue.

### Urges Review of Social Security Directive

Strong protests from the American Medical Association and others has led the secretary of the Department of Health, Education, and Welfare to hold letters from Social Security's Bureau of Health Insurance that ordered Medicare and Medicaid intermediaries to augment hospital utilization review by requiring a pre-admission certification program, and the use of national, regional or other appropriate data on length of stay by diagnosis to establish extended-stay cut-off dates.

In letters and visits with HEW Secretary Caspar W. Weinberger, AMA board chairman John R. Kernodle, M.D., urged that "... The Social Security directive be reviewed, not only from the standpoint of its validity under the Medicare law, but also with respect to its apparent preemption of functions given by the Congress to Professional Standards Review Organizations (PSRO).

"... We believe the purpose of an intermediary letter should be limited to administrative matters affecting carriers. If providers of service are affected we believe that any changes should be the subject of proposed regulations under which the providers and the carriers are given an opportunity to present their views. In the case of the intermediary letters under consideration, we question their validity and appropriateness at this time. We believe that they should not be issued at this time and that they would more appropriately be included in the PSRO regulations."

Social Security stated that the proposed new instructions in its intermediary letters "are intended to be supportive of the PSRO effort."

The reason for the new procedures, according to Social Security, is "increasing public concern at all levels over the need for more effective utilization of health care while maintaining or improving the quality of care rendered."

Social Security describes the new instructions as "processes that are to be employed for the period prior

to the emergence of PSROs. Hospitals will require that the attending physician present appropriate documentation for use by the UR committee, or its representative, for approval of the hospital admission prior to—or at the time of—elective admissions, and within one working day subsequent to emergency or urgent admissions.

"A representative of the utilization review committee will review all applications for admission of Medicare beneficiaries; however, not all would be reviewed in the same depth. By employing a selection technique found appropriate by SSA, the utilization review committee will subject an appropriate number of the applications for admission to close, professional scrutiny. For example, the utilization review committee will be required to review intensively all questionable admissions (i.e., those involving questionable diagnosis, and treatments, for which close review is appropriate because of high cost, frequency of abuse, or propensity for potential misutilization).

"All admissions approved by the utilization review committee will be certified by the committee for a specific duration based on appropriate percentile of past data (or other data acceptable to the secretary). Where the committee does not approve the admission, the attending physician and the beneficiary is to be notified immediately, i.e., within 24 hours. Reviews of admissions are to be scheduled prior to or at the time of the expiration of the initial projected length-of-stay and in subsequent additional stays where the attending physician recommends and the utilization review committee approves continuing hospitalization. Appeal rights are to be provided to protect the beneficiary, hospital, and the attending physician from improper denials.

"The proposed new procedure calls not only for a change in timing of review but for analysis of utilization review findings and the correction of problems that are identified ..."

Social Security said the intermediaries would conduct

Continued



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on-site reviews to “verify that pre-admission certifications and subsequent reviews are made timely and conscientiously.” Carriers would be required to exchange information to identify “potentially aberrant patterns of service and to take appropriate corrective action.”

**Statewide PSRO Systems Likely to Be Few**

Some 150 physicians representing 38 state medical associations and foundations have visited congressmen and federal officials to make a case that statewide PSRO coordinating systems should be permitted when the program is implemented.

The government has indicated that statewide PSROs are likely in only very small states though the law contains no such restriction. Chief congressional sponsor of PSRO, Senator Wallace Bennett (R., Utah), insists the intent of the law is to bar statewide setups in larger states.

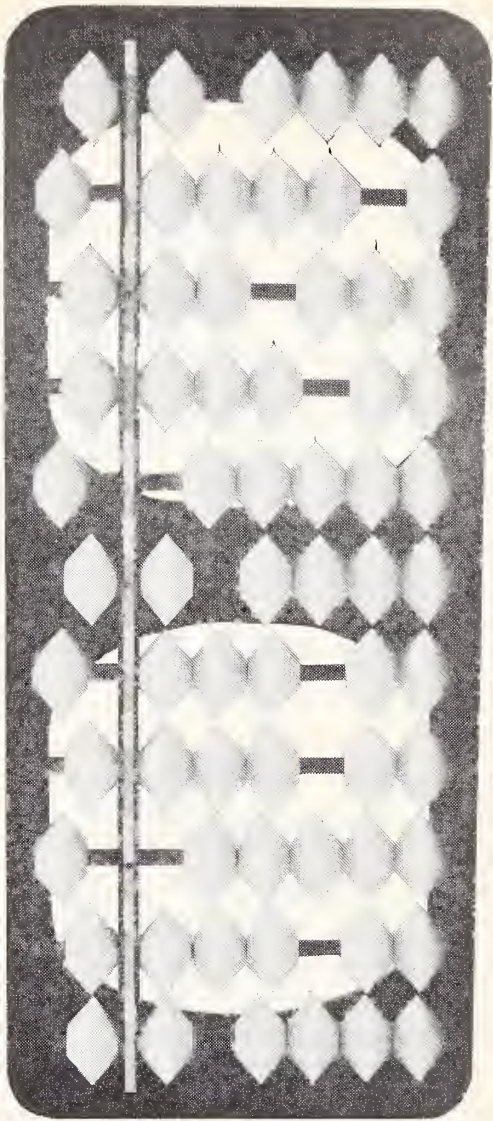
PSRO is the provision of last year’s Medicare-Medicaid amendments that calls for a structured professional review system for Medicare and Medicaid which will review initially all institutional care and later all care, including private physicians’ care.

Most of the lawmakers visited expressed sympathy for the position of the state groups and said they would transmit the concern to HEW. At a follow-up meeting HEW officials, however, indicated no change in policy is planned at this time.

Henry Simmons, M.D., Deputy Assistant Secretary for Health, said: “It appears clear that statewide PSROs would be difficult to square with congressional intent.” The legislative history of the provision, Dr. Simmons added, “makes plain” that there should be a number of PSROs in the larger states.

However, state and AMA representatives argued that there should be some arrangement under which a statewide umbrella organization can be part of the PSRO program, and that medicine desired a condition under which those state organizations which are interested and qualified could participate in a management role in the PSRO program in their states.

PSRO Director William Bauer, M.D., told the state representatives that final area designations won’t be made until November at the earliest and that states with a significantly large number of physicians can be expected to have more than one PSRO. Dr. Bauer stressed, however, that he will be as flexible as possible in operating the program.



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Two Stands of Organized Medicine Made Clear

In the exchange of communications between the HEW Secretary and AMA officials, two other stands of organized medicine were made abundantly clear.

Dr. Kernodle in a letter to the Secretary took issue with Social Security's opposition to current procedural terminology (CPT) as a coding system for carriers. Dr. Kernodle said the AMA has spent many years and hundreds of thousands of dollars in developing "what we think is the finest and most complete description of medical and surgical procedures that is possible."

Dr. Kernodle pointed out that the physicians of at least six states and the carriers operating in these states wish and stand ready to put CPT into operation. But Social Security continues to prohibit this on grounds that it might raise costs. Actually, Dr. Kernodle said, studies indicate that costs increases would be minimal at most and at least one state has found the use of CPT reduced costs.

"All the American Medical Association is asking is that those carriers who wish to use CPT be granted the opportunity."

In the same letter to the HEW Secretary, Dr. Kernodle wrote: "... The final and most important point we wish to make (and one that is at the core of many other areas of concern) is our firm belief that medical and health matters currently under the jurisdiction of the Social Security Administration and the Social and Rehabilitation Service should be under the jurisdiction of the Office of the Assistant Secretary for Health."

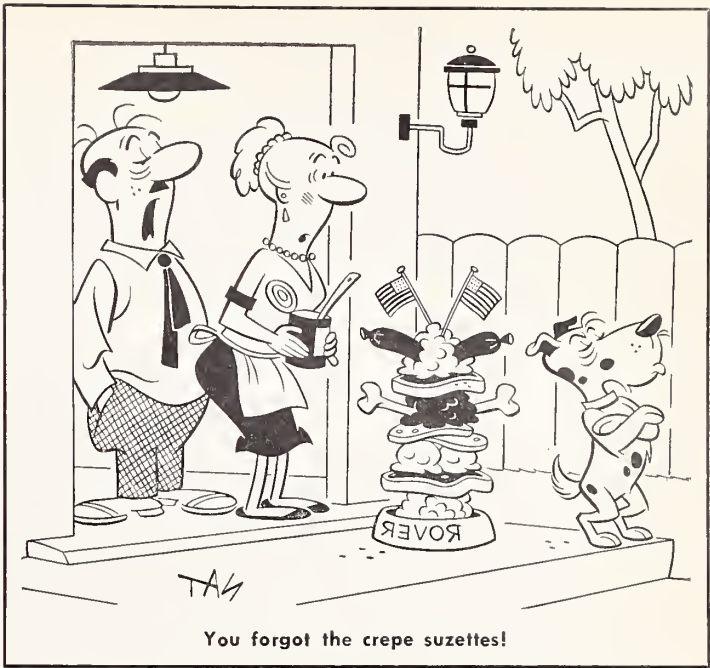
Senate Approves Reduced HMO Bill

The Senate has approved a drastically reduced Health Maintenance Organization bill (69-25) after liberal forces led by Senator Edward Kennedy (D, Mass.) fell back in retreat.

The measure that finally emerged after two days of debate called for spending \$805 million over three years to encourage development of pre-paid group practices or contract practice-type organizations. Last year, the Senate overwhelmingly voted a \$5.1 billion HMO program.

The legislation now goes to the House where a House health subcommittee has approved a \$280 million program. The Senate has been warned that any bill far exceeding the Administration's request for an experimental, \$60 million first-year plan may face a Presidential veto.

Confronted by surprisingly strong conservative opposition to the \$1.5 billion scale of the HMO bill re-



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ported by the Senate Labor and Public Welfare Committee, Kennedy was compelled to capitulate twice on the Senate floor. He first proposed an \$865 million substitute that would have relaxed many provisions of the original measure. At the end he switched support, successfully, to a Republican substitute introduced by Sens. Jacob Javits (R., N.Y.) and Richard Schweiker (R., Pa.).

The Javits-Schweiker bill authorized \$705 million. Added to this by the Senate was a \$100 million provision by Sen. William Hathaway (D., Maine) to foster HMO development in rural areas.

Kennedy said the revised bill would fund about 200 HMOs at a cost of some \$280 million over three years.

The bill adopted by the House Health Subcommittee several days before the Senate vote would aid about 100 HMOs at a cost of some \$280 million over three years. This bill still must be voted on by the House Commerce Committee and the House.

Criticizing the original HMO bill, Sen. Robert Taft, Jr., (R., Ohio) said the Senate would be "unwise to propagate by legislation a remedy for health care which has not yet passed any of the necessary tests. Before we even have a chance to get the test models off the ground, it is now proposed to fly with a whole fleet of HMOs."

## Joint Malpractice Commission Planned

The creation of a new Joint Commission on Medical Malpractice is being planned by major medical organizations as a means of curbing the rising number of damage claims and controlling health care costs.

Joining in the new venture would be the American College of Surgeons, American College of Physicians, American Hospital Association, American Medical Association, and representatives of medical specialty societies.

The plan was discussed by John R. Kernodle, M.D., Burlington, N.C., chairman of the AMA Board of

Trustees, in a speech before the American College of Obstetricians and Gynecologists meeting in Bal Harbor, Fla.

"While the AMA has been active in the commission's formation," Dr. Kernodle said, "we are fully aware that it is only through joint action that the malpractice issue can be met."

"The commission will gather and disseminate information on the nature, frequency, costs, and causes of malpractice claims . . . and recommend equitable and appropriate ways of minimizing the claims problem."

## Blasts Budget Health Program Cuts

John A. D. Cooper, president of the Association of American Medical Colleges, has blasted the Nixon Administration's proposed budget cuts for fiscal year 1974, saying they present a serious financial blow to medical education, biomedical research, and health care.

"Without advance warning and apparently without any real understanding of the consequences of their decision," Dr. Cooper said, "the Administration is seeking to terminate support for research training, Community Mental Health Centers, Hill-Burton hospital construction, the Regional Medical Program, and capitation support for schools of Veterinary Medicine, Pharmacy, Optometry and Podiatry. In nearly all other areas of the proposed budget, the President is asking the Congress to curtail or cutback federal monies for health."

According to Dr. Cooper, federal support will be reduced 15% below the level provided for in the President's amended 1973 budget which contained \$500 million less for health programs than his original fiscal 1973 budget. The FY '74 budget is 25% less than the schools had anticipated.

"As a result of decreased federal funds the schools will be forced to discharge about 1,400 faculty members, unless other support can be found. In addition to faculty cuts there will be a 15% decrease in supporting staff positions," Dr. Cooper said. ◀

## New Instructions for Shipment of Animal Heads

### For Rabies Examination Offered by Health Board

The Indiana State Health Commissioner has published instructions covering the shipment by bus express of animal heads for examination for rabies. Copies of the applicable National Express Tariff regulation may be obtained by writing the Indiana Bureau of Laboratories, State Board of Health, 1330 W. Michigan St., Indianapolis 46206.





## Placidyl® (ETHCHLORVYNOL)

### Brief Summary

**Indications**—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

**Contraindications**—Drug hypersensitivity and porphyria.

**Warnings**—Not recommended during the first and second trimester of pregnancy. Caution patients of possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, blurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

**Precautions**—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitriptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient dizziness or ataxia may occur.

**Adverse Reactions**—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction (manifested by urticaria) have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 307454



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The indications, contraindications, complications and minimal technique of total hip arthroplasty are discussed so that the non-orthopedist may have some understanding as to what is being done for his patients.

## Total Hip Arthroplasty A Resume for Non-Orthopedists

MERRILL A. RITTER, M.D.  
Indianapolis

THE complete replacement of a diseased or failed reconstructive hip joint by an artificial hip, fixed to the pelvis and femur with acrylic cement, works. Since the development of a self-curing acrylic cement to bond component parts of prostheses to bone, the success of the total hip replacement has been remarkable. Mr. John Charnley and Mr. G. K. McKee initiated their total hip replacements about 1960. Since then reports have continued to show an unbelievable 95%-or-better success rate.<sup>1-3</sup>

The success of this operation is well known to the orthopedic surgeon but many non-orthopedic surgeons and physicians are still puzzled by what is done, the indications, the contraindications, the complications and what results are to be expected.

From the Department of Orthopaedic Surgery, Indiana University Medical Center, 1100 W. Michigan St., Indianapolis 46202.

### What Does the Operation Do?

The head and neck of the femur and subchondral bone of the acetabulum are removed down to raw cancellous bleeding bone. An acetabular component of metal (McKee-Farrer) or plastic (Muller or Charnley) is then fixed to the remaining acetabulum with an acrylic cement. This cement is not a true cement but the mixture of a liquid and a powder to form a doughy compound which is then squeezed into all of the trabeculae and irregular surfaces of the acetabulum and prosthesis. It hardens in about 10 minutes, and holds the bone and prosthesis by contact with their irregularities. The medullary cavity of the femur is reamed out to accommodate a metal femoral component (all types of prostheses). The acrylic cement is then pushed into the marrow cavity and the prosthesis into the cement. The new hip joint is then reduced so there is now only motion between the two inert com-

ponent parts, thus no pain. The patient could probably walk off the table as far as the hip is concerned but a variable length of time is needed for soft tissue healing. Our patients are up bearing weight in three to five days with crutches or a walker. The above is common to all types of total hip arthroplasty. There is one big difference, however, whether or not the greater trochanter with its abductor muscles (gluteus medius and gluteus minimus) are removed and transposed distally on the proximal femur. Some feel this adds to the morbidity and therefore do not remove the trochanter, whereas others feel it is necessary for a biomechanical reason. If the trochanter is removed, transposed distally, and fixed with wire, the patient needs crutches for about 6 weeks followed by a cane until the limp subsides. If the trochanter is not removed the cane is still necessary until the limp subsides. (At Indiana University Medi-



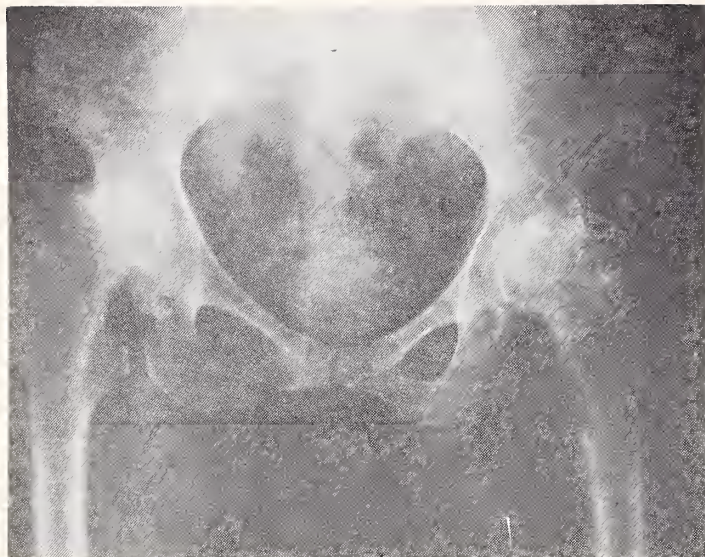


FIGURE 1A

A 73-year-old white female with bilateral hip pain for 10 years. Limited motion and ambulation with walker.

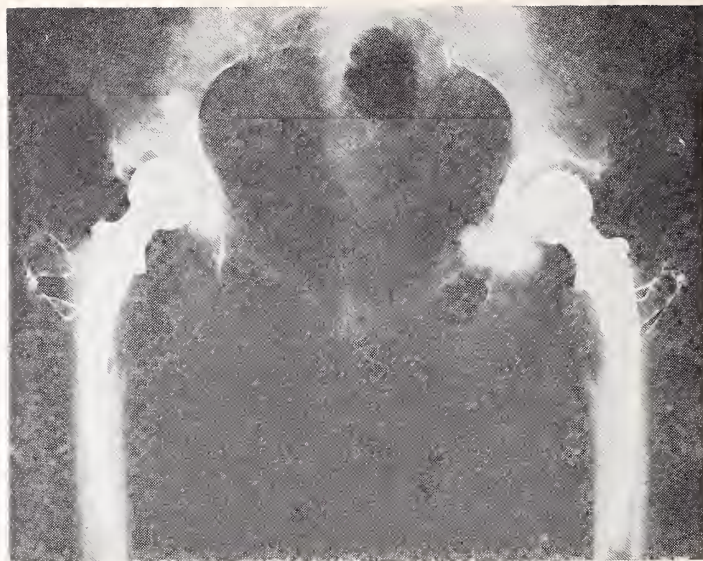


FIGURE 1B

One year postoperative bilateral Muller total hip replacements. Ambulating with no pain or external support.

cal Center we feel that the trochanteric removal and advancement is very necessary).<sup>4</sup>

### Indications

Any hip disease (Fig. 1) or failed previous hip surgery is amenable to total hip arthroplasty [i.e., hip fusion, cup arthroplasty (Fig. 2 and 3), Austin-Moore or Thompson (Fig. 4) prosthesis, hip osteotomy (Fig. 3 and 4), etc.] except for previously infected hips. We tried to limit this to the older and severely crippled individual because the longevity of the prosthesis and cement is presently only known for

about 10 years. All indications show that it will probably last at least twice that long.

### Contraindications

There is only one real contraindication, a previous hip infection. One must, however, weigh age as another possible factor because the longevity of the cement and prostheses have not been determined.

### Complications

The operation is performed by the Indiana University Medical Center staff both at the University

Hospital and Veterans Administration Hospital. Over 200 total hip arthroplasties have been performed. The following complications will be estimated from 175 total hip arthroplasties done at the University Hospital between September 1969 and March 1972.

### Infections

There have been three infections (1.7%), two of these had previous surgery and the organism was cultured from the hip prior to insertion of the total hip. The third developed pain nine months postoperative. All three required removal of the prosthesis (one died of CVA before

FIGURE 2A

A 62-year-old white female two years postop right hip fracture and nailing. Three years postop cup arthroplasty for a failed previous hip fracture. Ambulating with a walker and considerable pain.

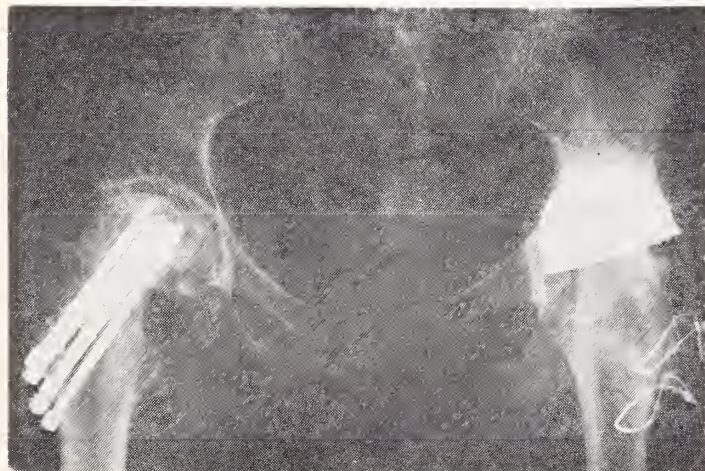


FIGURE 2B

One year postoperative bilateral Charnley total hip replacements. Ambulating with no pain or external support.





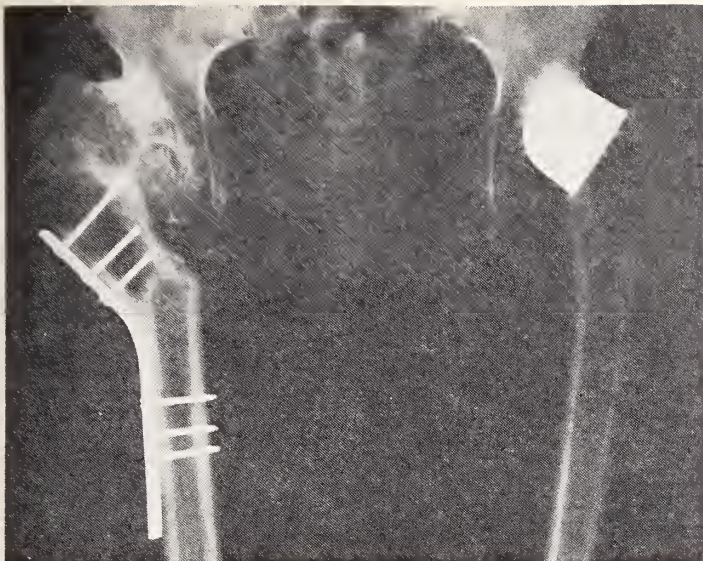


FIGURE 3A

A 58-year-old white female 20 years postoperative angulation osteotomy and 10 years postoperative cup arthroplasty. Bilateral hip pain, limited motion, and ambulating with a walker.

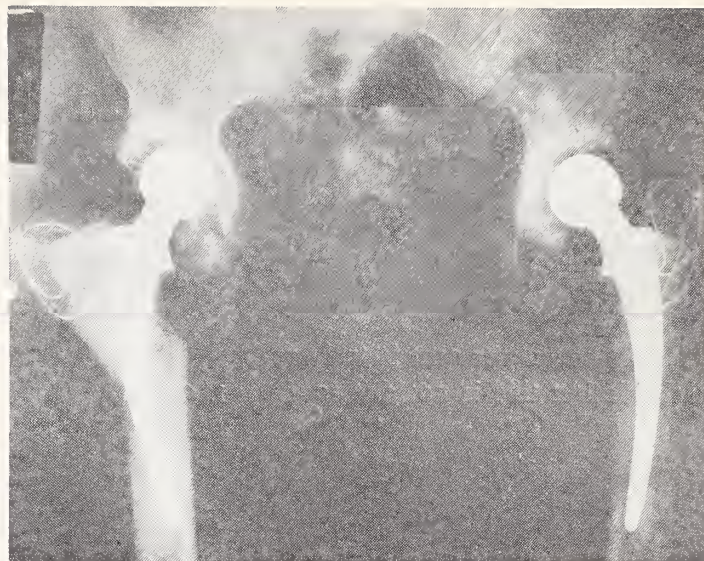


FIGURE 3B

One year postoperative bilateral Muller total hip replacements. Ambulating with a cane in the left hand but no pain.

the prosthesis was removed) leaving the patient then with a pseudoarthrosis which is painless, two to three inches short, and requiring a cane for support indefinitely.

#### *Thrombophlebitis and Pulmonary Emboli*

Phlebitis still plagues the patient with hip surgery even though he is ambulating within three to four days. In the first 127 patients, Coumadin was used prophylactically. Clinical thrombophlebitis developed in five (3.9%) and pulmonary emboli in 2 (1.6%) with

one death. Since then we have used a regime of Low Dose Heparin and our results show an alarmingly high thrombophlebitis rate of 12.5% (6 patients) and nonfatal pulmonary emboli of 4.2% (2 patients); however, there may be some other contributing factors which we are now looking into. Despite even the 12.5%, this is far from the 39%<sup>2</sup> previously noted in untreated hip surgery patients.

These new hip joints do dislocate (2.8%). Three of these were of the Charnley design with a femoral head

diameter of 22 mm. For this reason the position of the acetabulum and femoral components must be quite exact, as stated by Mr. Charnley.<sup>1</sup> Other complications such as heel sores (28 patients), wound bleeds (40 patients), fractured femur (one patient), and prosthetic loosening (2 patients) can be avoided if strict attention is paid to the patient before, during and after surgery.

#### **Results**

Except for the three infections,

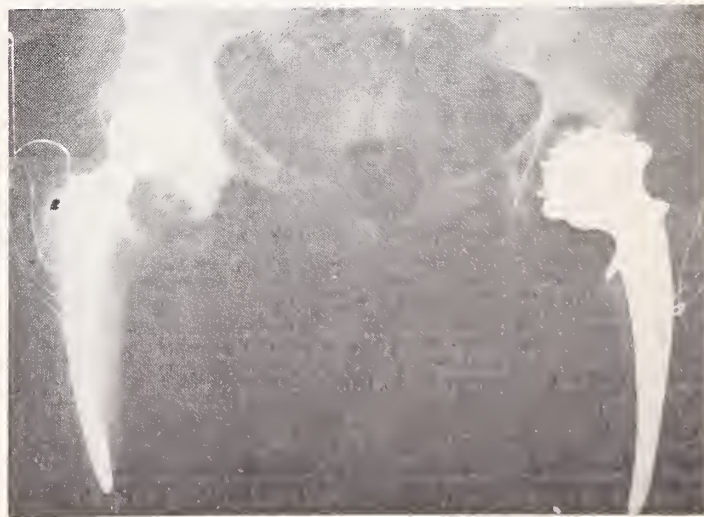
FIGURE 4A

A 74-year-old white female four years post-valgus osteotomy on the right and three years post-Austin Moore replacement on the left. Severe pain. Ambulating with two canes.



FIGURE 4B

Three years postoperative left McKee-Farrar and two years postoperative right Muller total hip replacement. No pain in either hip but continues to use a cane in the right hand for weakness of the left hip.





one recurrent dislocation and fatal pulmonary embolus, all of the patients (97.2%) have either an occasional soreness or no pain, ambulate with practically no limp and have a range of motion which is more than adequate.

Discussion

Ninety-seven per cent is truly remarkable but this is not due to the

surgeon but to the cement and prosthesis. It is our hope that those of you who have patients with hip disorders will understand what is done, and what you can expect from the total hip arthroplasty. This is an operation which helps the older person with hip disease.

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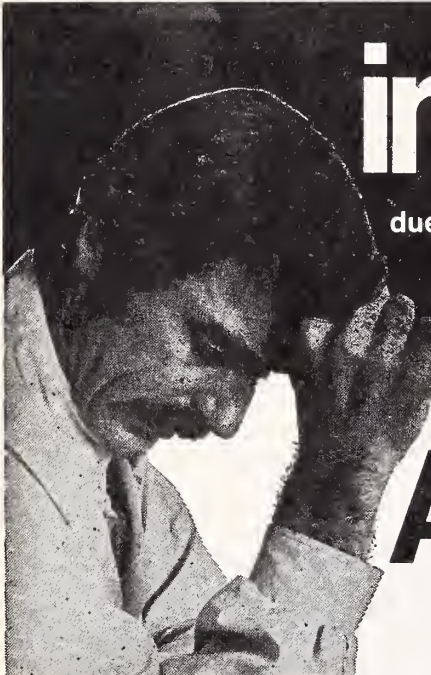
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**Adverse Reactions:** Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.

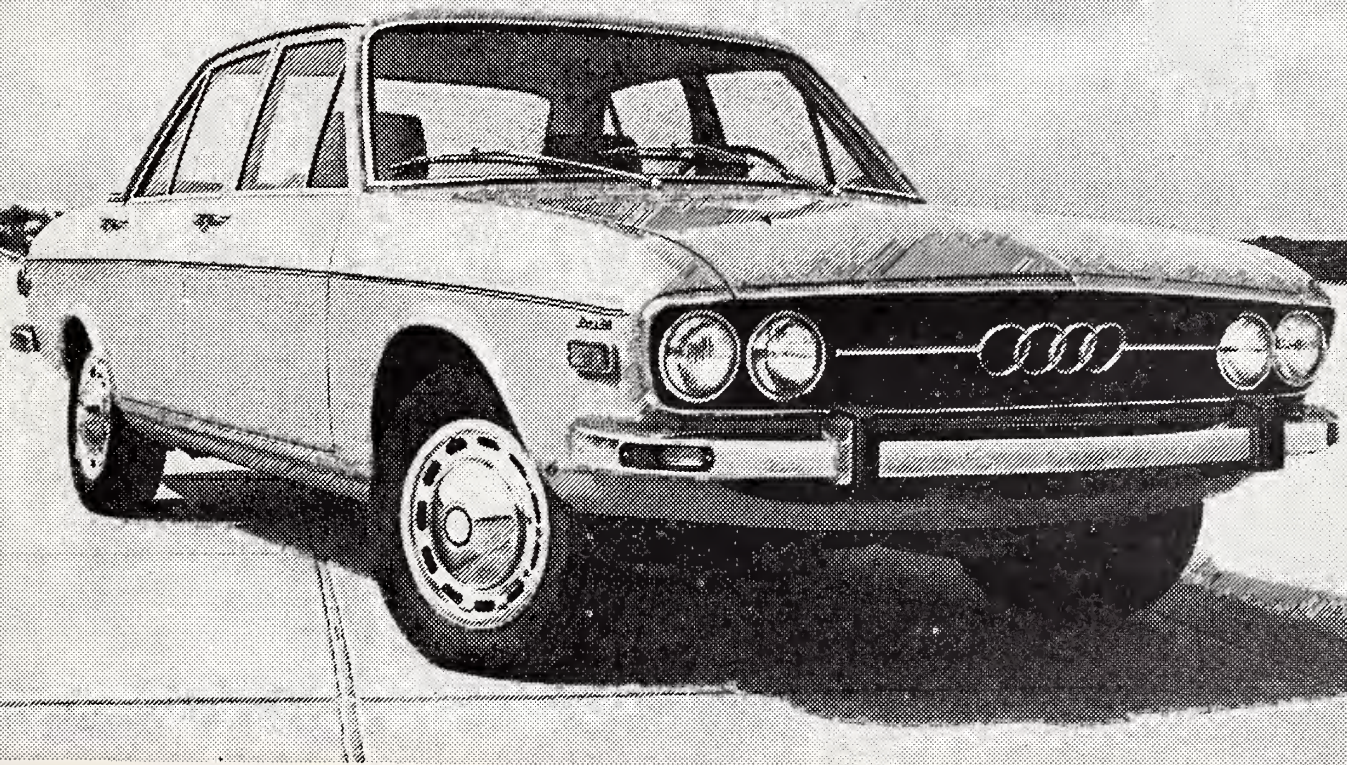
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# Uretero-Neo-Cystostomy in Children by the Method of Lich

RODNEY A. MANNION, M.D.  
LaPorte County

**S**URGICAL cure of vesico-ureteral reflux by extravesical operation (the Lich method) is desirable because it preserves a normal ureteral orifice and expedites future catheterization. This was described in 1962 and consists of an extravesical trough approximately 3 cm in length into which the ureter is placed. The vesical musculature is gently sutured over the ureter, which, when healed, creates a tunnel within the bladder wall. The eponym "Gregoir" is used in Europe for this same operation. It is the simplest and most direct procedure for curing reflux in normal sized or slightly dilated ureters. I used the Lich method<sup>1</sup> in the following five children.

## Case Reports

CASE #1 (Memorial Hospital 65212, Michigan City, Indiana)

Read before the Indiana Chapter of the American College of Surgeons in Indianapolis May 3, 1973.



FIGURE 1-A  
(Case #1) Voiding cystogram showing bilateral, massive reflux.

Four-year-old white female had recurrent urinary infections for 2-3 years. Voiding cystogram on 2/7/68 under general anesthesia (Downing, Mannion and Sanchez<sup>2</sup>) showed bilateral complete vesico-ureteral reflux (Figure 1-A). Cystoscopy revealed slightly dilated "stadium" shaped ureteral orifices as described by Lyon.<sup>3</sup>

Reimplantation into an extravesical trough on 3/26/68 was followed by fever for 4-5 days which responded to the use of chloramphenicol and kanamycin. She was discharged asymptomatic and fully healed on the eleventh postoperative day.

Intravenous urograms on 2/17/69 and 11/13/70 were normal and voiding cystogram on 2/10/72 showed no reflux (Figures 1-B and C). She remains asymptomatic.

CASE # 2

(Memorial Hospital 73556, Michigan City, Indiana)

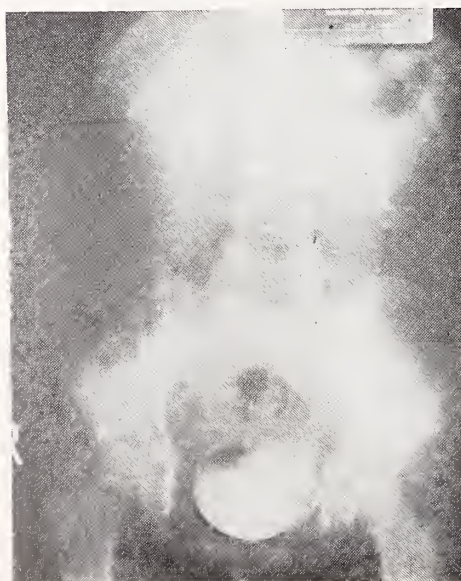


FIGURE 1-B  
(Case #1) Follow-up urogram is normal.

This nine-year-old white female had the usual syndrome of recurring urinary infections, and complete bilateral reflux was noted on 10/10/70 (Figure 2-A). Normal appearing ureteral orifices were present and bilateral reimplantation extravesically was performed on 10/16/70. I was especially careful to sever all the fibers down to vesical mucosa prior to burying the ureters in the musculature. Also, the hiatus was seen to be well open at the end of the implantation.

She healed uneventfully and went home on the ninth day after surgery. Intravenous urogram was normal on 1/15/71 (Figure 2-B). The report of the voiding cystogram on 2/25/72 is as follows:

"Essentially normal voiding cystogram without evidence of ureteral reflux. Anatomic deformity of the right lateral bladder wall in the region of the right uretero-vesical junction very likely from previous operative procedure." (Figure 2-C) The patient is free of symptoms without pyuria.

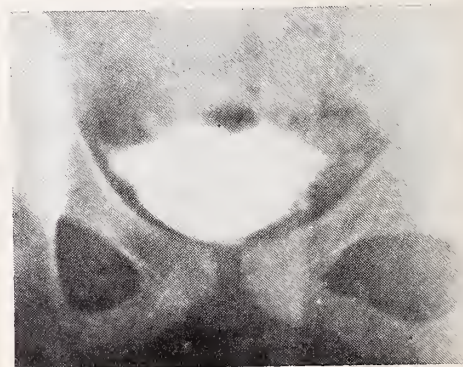


FIGURE 1-C  
(Case #1) Voiding cystogram four years postoperatively with no reflux.





FIGURE 2-A

(Case #2) Preoperative massive reflux.



FIGURE 2-B

(Case #2) Normal postoperative urogram.



FIGURE 2-C

(Case #2) Normal postoperative cystogram.

### CASE # 3

(LaPorte Hospital 11-358, LaPorte, Indiana)

A previous diagnosis of duplication anomaly of the right ureter and complete reflux into both segments was made in this four-year-old white female three months prior to surgical correction on 4/19/71. Dissection proved that the ureters joined intramurally. This was reimplanted in the usual fashion by constructing a 3-4 cm trench and suturing the vesical musculature over it with interrupted 3-0 chromic catgut sutures. The left ureter was not touched.

Again healing was primary and the clinical course uneventful. She went home eight days after surgery. I have tried unsuccessfully to contact the parents of this child but they apparently left LaPorte and are completely lost to follow-up. A telephone conversation with the mother in January 1972 revealed that the child is well and has had no serious febrile illnesses.

### CASE # 4

(LaPorte Hospital 2-370, LaPorte, Indiana)

Voiding cystogram on this three-

year-old white female in November 1971 revealed bilateral, total reflux. Reimplantation of 1/11/72 has been clinically successful but not enough time has elapsed to get follow-up x-rays. It is unwise to check these cases before complete healing and resolution of the vesical scar has occurred.

### CASE # 5

(LaPorte Hospital 11-175 and 30-642, LaPorte, Indiana)

Diagnosis of bilateral reflux in this white female was made at age two by voiding cystourethrography. On 1/20/72, at age four years, I performed a Lich implantation. The immediate postoperative hours were complicated by prolonged apnea, presumably from a reaction to Anectine. Pseudo-cholinesterases, however, were normal (0.26 delta pH; normal 0.41-0.65 delta pH). No residual effects remain but she didn't breathe spontaneously for five hours. Discharged fully healed after seven days and the sutures removed in my office after a few days. X-rays will be done in due course.

### Discussion

Habib and associates,<sup>4</sup> in their admirable monograph, give a good critique of the Lich ureteral reimplantation. They enumerate the ad-

vantages, such as speed in execution, success and simplicity; that it is extravesical and that the normal intramural obliquity is re-established without interrupting the continuity of the ureterovesical mucosa. Dr. Lich, in a personal communication to Habib in 1965, stated that the procedure worked poorly with dilated ureters. My Case #3 was a duplicated, slightly dilated ureter and seems to have healed with good clinical results. It is very unfortunate that the patient is lost to follow-up. Nevertheless, factors such as infection may affect the success of the implant more than size alone. Therefore, enlargement of the ureter may be only a relative contraindication to use of the procedure.

Lich reported only seven obstructions in 136 ureters<sup>5</sup> which is a lower percentage than many of the other standard uretero-neocystotomies and perhaps constitutes a significant advantage to the Lich method. The cutting of a circular fibrous band at the ureterovesical mucosal junction, which allows the contracted ureter to expand, is paramount to the success of the surgery and prevention of post-surgical obstructions. This dissection might have been deficient in my Case # 1, which would account for the postoperative sepsis. I have also found it

vital to have a commodious hiatus at the proximal end of the tunnel.

Finally, studies in dogs indicate that the major circulation to the lower ureter derives from the bladder musculature and that the caudal artery from the ureter above tends to function only when the ureter is severed.<sup>6</sup> Thus, physiological evidence supports placing the ureter into a trough of bladder muscle and not detaching the ureter entirely from the bladder in the dissection.

Summary

1. Five cases of ureteral reimplantation are presented. These were successful due to simplicity of

execution and preservation of good blood supply to the lower ureter afforded by the Lich technique.

2. This is the ideal initial way to cure reflux, because if future examination or surgery become necessary the intravesical area is still virgin territory.

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INDIANA STATE BOARD OF HEALTH  
MONTHLY REPORT — May 1973

Disease	May 1973	Apr. 1973	Mar. 1973	May 1972	May 1971
Animal Bites	1038	1011	825	1277	1210
Chickenpox	715	919	1414	658	357
Conjunctivitis	336	242	246	254	218
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	27	41	100	22	20
Gonorrhea	796	755	942	634	527
Impetigo	112	82	101	80	79
Infectious Hepatitis	41	34	65	53	68
Infectious Mononucleosis	59	115	105	126	115
Influenza	1310	2129	5727	705	810
Measles					
Rubeola	100	105	122	219	720
Rubella	153	212	278	103	437
Meningococcic Meningitis	1	0	0	1	7
Meningitis, Other	1	5	2	1	6
Mumps	151	202	138	126	837
Pertussis (Whooping Cough)	1	7	1	79	9
Pneumonia	545	457	792	357	295
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	1469	1031	1653	1114	724
Syphilis					
Primary & Secondary	17	45	21	14	28
All Other Syphilis	84	92	160	85	83
Tinea Capitis	5	6	13	2	0
Tuberculosis (Active)	75	45	68	57	99



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**Warnings:** Patients with severe cardiac disease should be given this medication with caution.

Fever and possibly heat stroke may occur due to anhidrosis. In theory a curare-like action may occur, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

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**Precautions:** Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

**Adverse Reactions:** Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

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**\*Indications:** Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

**Contraindications:** Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

**Warnings:** Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia ( $> 5.4$  mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently — both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides

are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

**Precautions:** Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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# Disability Insurance under Social Security

M. CORNACCHIONE, M.D.  
Indianapolis

**W**HENEVER a physician is asked to furnish a medical report in connection with a patient's claim for social security disability benefits, it's a reminder that social security is not just for the retired—it also provides important financial help for people who cannot work because of a serious illness or injury. Currently, over 3 million men, women and children receive social security disability checks every month because someone in the family—usually the breadwinner—is disabled. Their payments total almost \$5 billion a year. In addition, more than 76 million working men and women are insured for disability benefits as a result of their earnings—wages or self-employment—under social security. Beginning July 1, 1973, full Medicare protection is extended to persons under age 65 who for at least 24 consecutive months have been receiving monthly social security benefits because they are disabled.

A person under 65 can receive monthly disability benefits if he has a physical or mental impairment severe enough to prevent him from doing any substantial gainful work for a year or longer. Benefit amounts are based upon a person's earnings under social security. Selected applicants for disability benefits—whether they subsequently receive monthly benefits or not—are referred for services of the Indiana Rehabilitation Services, Vocational Rehabilitation Services Division. Such services include counseling,

teaching new employment skills, training in the use of prosthesis, and job placement.

## From a Small Beginning

The original Social Security Act of 1935 provided benefits only for the retired worker. It was not until 1954, when the disability "freeze" provision was added, that the law gave some protection to the disabled worker. Under the freeze, years when a worker earned little or nothing because of disability were not counted against him later in deciding if he was eligible for retirement benefits, or in figuring his retirement benefit amount. To be eligible for the freeze, the worker had to have a disability that was expected to be of "long-continued and indefinite" duration.

Two years later, monthly cash benefits were provided for disabled workers aged 50 to 64, and also for the disabled adult sons and daughters of retired or deceased workers if the son or daughter had been continuously disabled since childhood.

Over the years, the program has been further improved. The minimum age limit of 50 for payment of benefits to disabled workers was eliminated; "long-continued and indefinite" duration was changed so that an insured worker could be eligible if his disability had lasted or could be expected to last for at least 12 months; fewer years of covered employment were required for a young worker to be insured for disability; and benefits were provided for disabled widows (between ages 50 and 60) of covered wage earners. The latest change is,

of course, Medicare protection for disabled persons under 65.

## Who Can Get Benefits?

Social security disability benefits can now be paid to:

*A disabled worker under 65 and his family, if he has worked under social security for a certain length of time—ordinarily 5 to the 10 years preceding the onset of disability. (Special provisions apply to workers disabled by blindness allowing them to qualify with even less work under the program.) For the worker who becomes disabled before he reaches 31, the work requirement ranges down with age to as little as 1½ years.*

*A person continuously disabled since childhood (before age 22), if one of his parents (in some cases, a grandparent) who is covered under social security retires, becomes disabled, or dies. The mother of the disabled son or daughter may also receive monthly benefits as long as she has the child in her care.*

*A disabled widow 50 or over, if her late husband was covered under social security, and if she meets the specified level of medical severity. This also applies to disabled dependent widowers and certain disabled surviving divorced wives.*

## Reporting Medical Evidence

When a patient applies for benefits, he is asked to submit medical evidence to support his claim. This

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Dr. Cornacchione is chief medical officer of the Disability Determination Division of Indiana Rehabilitation Services, 932 Illinois Bldg., Indianapolis 46204.



evidence usually consists of data from the records of his treating physician, clinic or other medical source. Our experience with the disability program in Indiana indicates that in about three out of five cases no further medical development is needed because the treating source already has enough information on record to provide a good picture of the applicant's condition and how it limits his ability to work.

This information may be requested on the patient's behalf by a social security officer—or, more often, by the Disability Determination Division of Indiana Rehabilitation Services. This is the full name of the agency in Indiana that evaluates social security disability claims for Hoosier residents. Like other state agencies throughout the country that work with social security in the disability insurance program, the Disability Determination Division in Indiana includes both physicians and trained disability examiners on its professional staff. They form a balanced team of medical and non-medical people who can handle anything from a strictly medical issue to a complete assessment of the vocational factors which bear on the disability decision.

With the assistance of our staff of reviewing physicians, we endeavor to make these requests for medical information relate as directly as possible to the condition which the claimant states is the cause of his disability. The goal of the individually tailored request is to ease the medical reporting burden of the busy physician or clinic, without jeopardizing the claimant's right to have his case decided on the basis of all relevant information available.

The evaluating physician here in the Disability Determination Division never sees the patient. He depends heavily on information supplied by the physician or clinic to assess the severity of the applicant's impairment, its expected duration

and the extent of his residual functional capacity. The disability decision, therefore, rests largely on the quality of the medical evidence obtained. A detailed report from the treating source, including objective findings and laboratory procedures, will usually be sufficient for us to evaluate the claim and make a decision.

For example, if the patient experienced a myocardial infarction, we would look to the report submitted by the treating source for such information as date of occurrence, place and duration of the hospitalization, as well as results of x-rays, electrocardiograms, and other laboratory studies. Serial ECG tracings should, whenever possible, accompany the report so that our staff of physicians may also have the benefit of reviewing this essential documentation. Equally important is the medical history, including onset of chest discomfort, relationship to effort, intensity, location, radiation, regularity, and to what extent relief is obtained by rest or medication.

If a report does not contain all the findings necessary to make a proper decision, one of our reviewing physicians may recontact the medical source. However, the additional time required may delay the patient's claim and can add up to a significant additional program expense.

You can help speed the decision on your patient's claim by reporting all relevant data about his medical condition as promptly as possible.

Establishing the onset date of disability—often a key factor in determining the beginning date and amount of the claimant's benefits—is frequently difficult. Therefore, it is extremely helpful if the reporting physician includes the date of each important fact or finding. To save time, he may enclose photocopies of pertinent sections of the patient's

chart or of hospital or consultant's reports.

### Criteria for Evaluating Disability

In making disability determinations, our agency uses medical criteria developed by the Social Security Administration to insure uniform evaluation of all applicants no matter where they live, and to help simplify and speed the decision process. These criteria were worked out with the aid of practicing physicians, major medical organizations and SSA's Medical Advisory Committee.

Generally, a claimant who is not working can meet the social security definition of disability if he has an impairment or combination of impairments that are the same as, or medically equivalent to, any set of findings in the criteria. (This is the only way the *widow 50 or over* can qualify for disability benefits.) However, for *all claimants* whose impairments fall short of this test, such factors as age, education, and work experience added to the functional limitations imposed by the medical condition are taken into consideration in making the disability decision.

The complete criteria, including the medical findings listed by body system, are contained in a handbook designed especially for professionals who come in contact with the disabled population. The handbook describes impairments in terms of specific symptoms, signs and laboratory findings that are presumed to be severe enough to prevent a person from working for a year or longer.

The handbook may be obtained from the Disability Determination Division, 932 Illinois Building, 17 West Market Street, Indianapolis 46204. We also welcome any inquiries from physicians who wish to know more about the social security disability program and its policies and procedures. ◀



# Evaluation of Several Methods of Surgical Scrub

WALTER E. GOWER, M.D.  
Duluth, Minnesota

**T**HIS study was initiated to evaluate the effectiveness of several methods of surgical scrub employed for many years at the Department of Orthopedic Surgery at The University of Iowa.

## Materials and Methods

All surgical scrubs in the initial phase of this study were done by the author. Each method was limited to 10 minutes or less. The method of bacteriological evaluation employed was that described by Gale et al.<sup>1</sup> Prior to the surgical scrub the fingertips of the thumb and fingers were touched to the surface of the agar in such a manner that the fingernails broke the surface of the agar. This was done for both the right and left hands using separate blood agar plates. Immediately after the surgical scrub a new set of blood agar plates was imprinted. Sterile surgical gloves were then put on and the wrists secured with rubber bands. No attempt was made to keep the outside of the gloves sterile. After one, two, and three hours the gloves were removed and new sets of blood agar plates were imprinted. A new pair of gloves was used after the one- and two-hour plates were imprinted. Pre-powdered disposable gloves were used which are supplied sterile by the manufacturer. As a control, blood agar plates were im-

printed initially, hands were held in the air for 10 minutes but no scrub employed, and then a second set of plates was imprinted. Following this, sterile gloves were put on and subsequent plates were imprinted after one, two and three hours. Only one scrub or control was done each day. Five repetitions of each method of scrub and five controls were done and the results of the five repetitions were averaged. After the three-hour plates were imprinted, all 10 of the plates were incubated at 37° C for 24 hours. The numbers of bacterial colonies per fingerprint were then counted and totals for the 10 digits obtained. In a few cases there was such luxuriant growth on the pre-scrub plates that the colonies tended to merge. In these cases where the colonies per fingerprint exceeded 50, estimates were made as accurately as possible. The colony counts were done with the aid of a 2X magnifying lens. Greater than 95% of the colonies were *Staphylococcus epidermidis*.

Three methods of surgical scrub were in use at the time this study was initiated. These consisted of use of either PhisoHex (3% hexachlorophene detergent lotion), 10% aqueous solution of polyvinylpyrrolidone iodine, or scrubbing with tincture of green soap, drying with a sterile towel and immersing the hands and forearms in cylindrical tanks containing HIACA solution. HIACA solution is prepared by the hospital pharmacy and is composed of 70% isopropyl alcohol, 0.5% cetyl alcohol and 0.1% hexachloro-

phene. Three gallons of HIACA solution are placed in each of two cylindrical tanks, used for five days and then discarded. When PhisoHex or PVP iodine was used alone, fingernails were cleaned and a three-cycle scrub using a brush and lasting seven minutes was done, the hands were rinsed under running water, dried with a sterile towel and the blood agar plates imprinted. When PhisoHex, PVP iodine, or tincture of green soap scrubs were followed by immersion in HIACA solution, the hands were dried prior to immersion. After immersion in HIACA solution the hands were held in the air for three minutes prior to imprinting the blood agar plates. When the HIACA dip is used prior to surgery the hands are not dried with a towel but simply air dried for several minutes before putting on gown and gloves. To test the effectiveness of HIACA solution by itself without prior surgical scrub or cleaning of the fingernails, five trials were carried out employing only a two-minute period of immersion in HIACA solution.

In the second phase of this study one method, PhisoHex scrub followed by two-minute immersion in HIACA, was tested on seven individuals participating in two surgical procedures of total hip replacement arthroplasty on two different days. Two of the surgeons were the same for both procedures and thus nine sets of data were obtained. Blood agar plates were imprinted before scrub, after immersion in HIACA solution, and two hours later after the completion of the surgery.

Dr. Gower is in the private practice of orthopedics in Duluth, Minnesota. This paper was prepared during his period of residency at The University of Iowa College of Medicine.

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FIGURE 1.  
Surgical nurse dipping hands and forearms in HIACA solution for two minutes.



FIGURE 2.  
The fingertips are touched to the surface of a blood agar plate in such a fashion as to break the surface with the fingernails.

**Results**

The scrub index represents the number of bacterial colonies expressed as a percentage of the total number of colonies in the pre-scrub sample. The averages of five separate tests of each method are shown in Table I. The colony counts for the control increased during the three-hour period while wearing gloves. When Phiso hex scrub alone was used there were 26% as many colonies present after scrubbing as

before scrubbing but only 2% as many after one and two hours and 1% after three hours of wearing gloves. This appears to represent a continuing antibacterial action of Phiso hex during the three hours following scrub that was not observed when using PVP iodine. A two minute immersion in HIACA solution without prior scrub or cleansing of the fingernails was more effective than either Phiso hex or PVP iodine scrub alone and the

excellent antibacterial effect was maintained during the three hours after scrubbing. Phiso hex, or PVP iodine or tincture of green soap scrubs, when followed by two-minute immersion in HIACA, were slightly better than HIACA solution alone.

Table II indicates the results of nine trial uses of Phiso hex scrub followed by two minutes immersion in HIACA solution in two total hip arthroplasty operations. There was no growth on any of the blood agar plates imprinted just prior to surgery nor on six out of nine following the operation.

Use of two-minute immersion in HIACA solution following surgical scrub is now standard procedure in the Department of Orthopedic Surgery. Skin irritation from use of HIACA solution has been a very infrequent problem. It appears this method improves significantly on the results achieved by surgical scrub alone.

TABLE I  
SCRUB INDEX

	Pre-scrub (Percent)	Post-scrub (Percent)	1 Hour (Percent)	2 Hours (Percent)	3 Hours (Percent)
Control (no scrub) . . . . .	100	101	125	127	129
Phiso hex (3% hexachlorophene) . . . . .	100	26	2	2	1
PVP iodine . . . . .	100	38	53	35	35
HIACA . . . . .	100	3	0	1	1
Green soap plus HIACA . . . . .	100	0	0	0	4
Phiso hex plus HIACA . . . . .	100	0	0	0	1
PVP iodine plus HIACA . . . . .	100	0	0	0	1



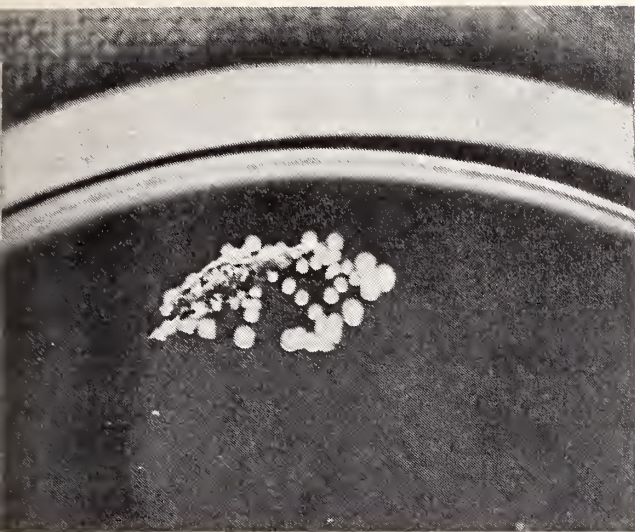


FIGURE 3.

Typical appearance of the colonies of *Staphylococcus epidermidis* which are obtained from one fingertip prior to surgical scrub.

TABLE II  
SCRUB INDEX BEFORE AND AFTER  
TOTAL HIP REPLACEMENT ARTHROPLASTY

	Pre-Scrub (Percent)	Post-Scrub (Percent)	Post-surgery (2 hours) (Percent)
R.J. ....	100	0	0
R.J. ....	100	0	19
J.T. ....	100	0	0
J.T. ....	100	0	0
T.O. ....	100	0	12
D.C. ....	100	0	1
B.W. ....	100	0	0
R.C. ....	100	0	0
M.S. ....	100	0	0

Reduction of the bacterial flora of the patient's skin and of the surgeon's hands to the lowest possible level is the objective of preoperative scrubbing and use of antiseptics. Attention to detail in the use of antiseptics can result in very effective control over the bacterial flora of the skin. The continuing quest to reduce the incidence of wound infection in clean surgical cases to the absolute minimum demands an interest on the part of every surgeon in understanding and controlling the many factors that play a role in the bacteriological environment of the operating room.

### Summary

A bacteriological evaluation of several methods of surgical scrub has been described. The use of HIACA solution, containing 70% alcohol, as a two-minute post-scrub dip is an effective method of reduc-

ing the bacterial flora of the surgeon's hands.

### REFERENCE

1. Gale, D., et al: Re-evaluation of scrub techniques for preoperative disinfection of surgeon's hands. *Ann. Surg.*, 155:107-118, 1962.

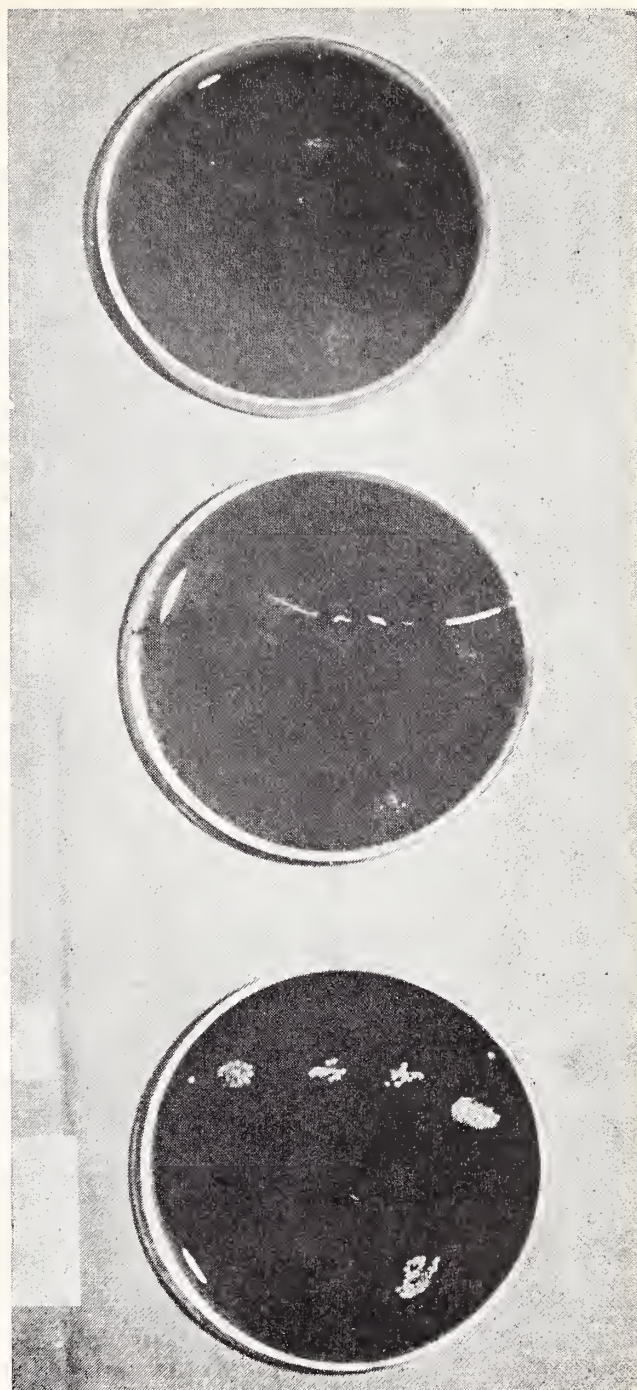


FIGURE 4.

Bacterial colonies are present on the pre-scrub blood agar plate and absent on the plates obtained after PhisoHex scrub and two-minute dip in HIACA. The top plate shows absence of bacterial growth three hours after scrubbing.



# An Alcohol Education Program for the General Hospital

H. PAUL CHALFANT, Ph.D.  
Valparaiso  
JOHN BOGUSLOWSKI, M.S.W.  
Hammond

THIS is a description of a program for the ancillary treatment of alcoholics designed for operation in a general hospital. It is currently operating in St. Margaret Hospital in Hammond. Its purpose is to institute a procedure for the assistance of private physicians in caring for their hospitalized (and outpatient) alcoholic patients. The program operates through the Social Work Department of the hospital with staff aid from the Northwest Area Office of the Indiana Division on Alcoholism (Department of Mental Health). The aim of the program is to develop in the hospitalized (or outpatient) alcoholic insight into the nature of his problem so that he can be helped to make plans to take further steps toward arresting his problem rather than continuing his repetitive and destructive drinking. Basically, the program consists of four sessions per week dealing with the development of insight into the problems of alcoholism. In addition, one individual session is held with a Social Worker to help expedite referrals to appropriate resources. This is, of course, with the full knowledge and approval of the referring physician. Patients attend the sessions at the direction of their private physician and written reports are given to such private physicians. It is as-

sumed that patients will normally attend one week of sessions, but will return for other sessions on an outpatient basis as seems appropriate to the patient and his physician.

## *Program Objective*

The basic objective of this program is to assist the alcoholic in developing insight into the nature of his problem so that further constructive steps can be taken. It is not anticipated that this program and this program alone will bring about recovery or permanent sobriety for the alcoholic. In fact, it would not be considered atypical if patients returned several times for renewed participation in the program. Rather, it is the goal of this particular program that each individual patient have a plan of action which can be followed after hospitalization that may lead to recovery. This plan will be developed by the social worker and patients, with approval of staff physician, Northwest Area Office of the Division on Alcoholism and referring physician.

## *The Program*

Basically, the program will consist of five sessions. Subject matter and content of these sessions is as follows:

### **Session I**

#### **What is Alcoholism?**

- I. Discuss briefly what we mean when we say alcoholism is an illness.
- II. Point out that there are progressive symptoms which will be

depicted in the film. Ask patient to look for them. (FILM)

III. Review briefly the symptoms. (Use Profile Charts called "The Course of Alcoholism.")

Questions for possible discussion:

A. What are some of the symptoms of alcoholism shown in the film?

## *Early Stages*

1. Making promises to stop drinking
2. Taking drinks before meeting people
3. Drinking at a certain time of the day
4. Drinking for that tired feeling, or for nerves

## *Middle Signs*

1. Lying about drinking
2. Taking drinks more often each day
3. Drinking alone
4. Drinking on the job
5. Week-end drinking bouts
6. Early morning drinking
7. Frequent bouts of real drunkenness.

## *Late Symptoms*

1. Drinking to live, and living to drink
2. Rarely eating
3. Lying in order to drink
4. Drinking as long as funds are available
5. Drinking every morning as a matter of course

Dr. Chalfant is chairman of the Department of Sociology, Valparaiso University, Valparaiso 46383, and Mr. Boguslowski is director of the Social Service Department of St. Margaret Hospital, 25 Douglas St., Hammond 46320.



6. Being constantly irritable and emotional
7. Staying drunk most of the time
8. Lacking in concern for family
9. "Shakes"
10. Frequent nausea

B. Did you notice that the symptoms became progressively more serious?

IV. Fill out the individual "Profile" sheets.

## Session II

### Physiological Effects of Alcohol

I. Build a readiness for the film. Be certain the participants know why they are seeing the film and what they are to look for.

II. Show the film: ("To Your Health" or "Alcohol and the Human Body")

III. After the film let the participants raise any questions about the film or physiological effects of alcohol not raised in the film.

### Suggested Questions

A. What happens to alcohol after it enters your stomach?

1. Small amount is absorbed through the stomach, but largest percentage is absorbed through the small intestine directly into the bloodstream and circulated throughout the body

B. What functions of your body are affected by alcohol?

1. Vision becomes blurred
  2. Speech becomes slurred
  3. Hearing becomes less acute
  4. Muscular coordination slows down reaction time
  5. Consciousness impaired
  6. Breathing becomes abnormal
  7. Heart action upset
- (Draw a picture of the brain on blackboard to show where these are affected.)

C. How does the body rid itself of alcohol?

1. 80% is burned (oxidized) by the liver

2. 20% is exhaled through the lungs and excreted by the kidneys

D. Does alcohol injure the brain?

1. Only after prolonged use
2. In chronic alcoholics there can be serious damage to the brain, liver and stomach

E. What physical symptoms and diseases can accompany alcoholism?

1. Frequent blackouts
2. Physical addiction
3. Neuritis
4. "Shakes"
5. Gastritis
6. Hallucinations
7. Convulsions
8. Delirium tremens
9. Wernicke's disease
10. Korsakoff's disease
11. Cirrhosis
12. Mallory Weiss syndrome
13. Pancreatitis

### Conclusion

Alcohol has many serious effects on the human body. Prolonged heavy drinking can result in serious permanent damage to the brain, the liver, and the stomach.

### Include in Each Day's Diet

Milk

Eggs

Meat, poultry, fish or cheese

Bread, whole-grain or enriched white

Cereal, whole grain or enriched

Potato

Other vegetables, including at least one green leafy vegetable

Fruits, citrus — oranges, grapefruit, lemons and limes

Fruit, other

Margarine, vegetable oil

## Session III

### Reasons Why People Drink

#### Goal or Purpose:

To examine various reasons why people drink. To build an understanding of why these reasons may be psychological and, therefore, dangerous, very often resulting in alcoholism.

I. What are the causes of alcoholism?

A. There is *no one* cause.

B. We can safely say that alcoholism *is not* caused by:

1. Alcohol alone
2. Genetic (physical) inheritance
3. An allergic reaction
4. An "alcoholic personality"
5. A particular beverage

II. Why do people drink?

A. Ask yourself "Why do I drink?"

We have learned that the alcoholic drinks for many reasons. You may have one particular reason but probably several.

B. What are some of the reasons why people drink? (List on the blackboard, allowing the group to give as many reasons as they can think of.)

III. After the group has exhausted their reasons, list as many of the following as were not already listed.

A. Alcohol is used to *escape* something.

1. To relieve *tensions* in meeting *environmental* problems. Some of these environmental problems are:

- a. growing up
- b. getting old
- c. social surroundings
  1. family
  2. neighbors
  3. business associates
  4. acquaintances
- d. loneliness
- e. boredom



- f. effects of disease
- g. family or marital difficulties
- h. job problems
  - 1. insecurity
  - 2. disagreement

B. Alcohol is used as a substitute for something.

- 1. Maturity (ability to cope with environment)
  - a. insecurity
  - b. guilt
  - c. substitute for personal relationships
  - d. substitute for challenging work
- 2. Self-expression and achievement (Sensitive, intelligent people often find their roles unrewarding and feel "hemmed in")
- 3. Courage
  - a. a cure for fears
  - b. shy people feel self-confident

#### Conclusion

Most people who don't get into trouble with alcohol do not drink for any of these reasons. I doubt that most of them could really give any specific reason for drinking. They may drink simply because they enjoy the taste of a mixed drink or simply because it is custom.

Drinking in any amount is much more dangerous than not drinking, but drinking for effect is *very, very* dangerous. As most of you well know, alcohol is, in the long run at least, a poor solution for your problems.

Also, any drinking of alcohol that leads to drunkenness is *very, very* dangerous, and can lead to alcoholism.

But for the alcoholic, one drink is *very, very* dangerous. He must find a way to live and solve his problems without alcohol.

#### Session IV

##### The Treatment Program

##### Purpose

To help the patient understand

the various kinds of treatment programs available to the alcoholic; to help him understand the nature of the clinic's treatment program and to give some idea of what we hope to accomplish. Also to discuss at least one personal program of recovery that has proved helpful.

I. Talk about the periods of repair and recovery.

A. 1-5 years following last drink, period of repair.

B. Period following is one of continuing recovery.

II. During this period of repair the following symptoms are not unusual:

- A. Fatigue (tiredness)
- B. "Craving sweets"
- C. Lack of appetite
- D. Insomnia
- E. Recurrent tension (nervousness)
- F. Thoughts and dreams of drinking
- G. Continuation of difficulties created by drinking (family, work, community)

III. Also, during this period outside help is indicated and should be sought. There are two major kinds of treatment. They are both important.

##### A. Physical Treatment

- 1. Vitamins to offset poor diet. Includes need for a good diet.
- 2. Drugs to control discomfort of withdrawal and nervousness.

**CAUTION:** These must be used under careful supervision of a DOCTOR.

3. Sometimes drugs such as antabuse (explain) are used. (We do not use them here.)

##### B. Counseling (Mental Treatment)

Learning to face reality and to face it without alcohol as a crutch.

1. Counseling — talking over problems with someone who is understanding and accepting. This talk

can be about almost anything.

2. Group Counseling — talking over problems with a group of people, all of whom have similar problems. Here we learn from the experience of each other. We help each other. AA is one type of group counseling.

#### IV. YOUR PERSONAL PROGRAM OF RECOVERY:

The program followed by AA is the best guide I know.

1. Commitment — person must *want* to recover.

2. Humility — recognize the problem is too much to handle alone — help is needed.

3. 24-Hour Plan — get through TODAY without a drink

4. 12-Steps — These steps provide a good guide to a way of life that will help one *stay sober* and *help others*.

The decision is yours!

1. You may start drinking again.

2. You may accept and continue treatment.

3. You may achieve and maintain complete sobriety.

#### Session V

##### Individual Treatment Program Plan

At St. Margaret each of these sessions is conducted by a member of the staff of the Northwest Area Office of the Division of Alcoholism with the assistance and attendance of a member of the staff of the Department of Social Work of St. Margaret Hospital. Such individual counseling as is appropriate is carried on by the Social Work staff members and the staff members of the Division on Alcoholism. For each patient before release from the hospital, some attempt is made to develop a plan of action for further treatment and this plan is forwarded to the patient's physician and discussed with



the patient as a part of the alcohol education program. Follow-up of patients for later study will be at the discretion of the individual physician.

### **Procedure at St. Margaret Hospital**

1. Any alcoholic examined and referred to the program by a physician will be eligible for participation. No individual will be admitted to the program who is not referred by a physician. The staff will not secure this physician referral.

2. Although it is assumed that most participants in the program will be hospital patients, the following provisions will be adhered to for the treatment of outpatients. Physicians referring outpatients may have their offices call the Social Work Department of Saint Margaret Hospital and inform staff of referral. The referring physician will continue to be the patient's physician and information concerning patients will be forwarded to physician.

3. For hospitalized patients, the physician must order this service by placing request in patient's chart under Doctor Orders. It would be greatly appreciated if physician would call Social Worker and give any information he has as to patient, so that treatment plans can be more detailed.

4. Since there can be little hope for success without the patient's cooperation, it is suggested that the physician, in whom the patient has trust, explain the referral to the patient. The Social Worker will see the patient individually prior to the sessions to answer questions the pa-

tient has and to place him at ease.

5. Patients will be picked up and returned to their appropriate wards by designated members of the hospital staff who will sign the patient off-and-on to the ward. Their mode of transportation will be the wheelchair.

6. Progress notes and comments to the attending physician will be placed daily in the patient's chart following each session. At times the Social Worker will contact the physician personally following the sessions if deemed appropriate by the staff.

7. This is a completely voluntary program and no patient will be forced to attend a session if he refuses. A patient may leave any session before its completion but must be taken back to his ward by staff personnel. The physician will be contacted.

8. The program will be held in a classroom at St. Margaret Hospital at 1:00 p.m., Monday through Friday afternoon and will last until 2:30 p.m.

### *Other Matters*

1. The institution of this program at St. Margaret implies no change in policy toward alcoholic patients in the emergency room. Such patients as require hospitalization will continue to be hospitalized as in the past and, if the attending physician recommends, will participate in the alcohol education program. *Alcoholics who do not need hospitalization should not be hospitalized* and may, if the attending physician so desires, be referred as outpatients to the program.

2. Staff members of the Northwest Indiana Alcoholism Clinic will be the only recognized body assisting in the program. Only staff members approved by the Director of Social Services at St. Margaret Hospital will be accepted in this cooperative program. All cooperative staff must adhere to the rules, regulations and philosophy of St. Margaret Hospital. No medical opinion is to be expressed by the staff unless directed by the sponsoring physician or patient's private physician.

3. The staff of the Northwest Indiana Alcoholism Clinic will be furnished, at no cost, classroom space for development of the Alcoholic Program. No office space will be allotted to the staff and no fee will be paid them for their service by the St. Margaret Hospital of Hammond.

4. The services of the St. Margaret Hospital Alcoholic Program will be at no financial cost to the patients.

5. The St. Margaret Hospital Alcohol Education Program will have a Medical Advisor. The Medical Advisor will be available to the staff for consultation concerning medical material which will be presented to patients by staff. He will be the resource person who will be called upon to field medical questions dealing with physical reactions to alcohol. He will *not* prescribe medication nor hospitalize individual patients. This will be the responsibility of the referring physician. He will advise and consult with the educational staff, not with the individual patient. ◀



# Annual Meeting Dates of Professional Medical and Allied Organizations

## **AMERICAN MEDICAL ASSOCIATION ANNUAL CONVENTION**

**Date** Dec. 1-5, 1973  
**Place** Anaheim, Calif.

## **NORTHERN INDIANA PSYCHIATRIC SOCIETY**

**Date** Fourth Wednesday of every month, September through June  
**Place** For location and program, inquire Jon Leipold, M.D., 919 E. Jefferson Blvd. South Bend 46622

## **INDIANA STATE MEDICAL ASSOCIATION CONVENTION**

**Date** October 6-11, 1973  
**Place** Indianapolis Convention-Exposition Center

## **INDIANA ACADEMY OF FAMILY PHYSICIANS**

**Date** April 2-4, 1974  
**Place** Stouffer's Indianapolis Inn

## **INDIANA PSYCHIATRIC SOCIETY**

**Date** Second Wednesday of September, November, January, February, March and April  
**Place** For time and place, inquire Wesley A. Kissel, M.D., 1815 N. Capitol Ave., Indianapolis 46202

## **INDIANA SOCIETY OF INTERNAL MEDICINE AND AMERICAN COLLEGE OF PHYSICIANS**

**Date** October 10, 1973  
**Place** Indianapolis Convention-Exposition Center

## **INDIANA CHAPTER, AMERICAN ACADEMY OF PEDIATRICS**

**Date** Sept. 26-27, 1973  
**Place** Ramada Inn, Nashville

## **INDIANA ASSOCIATION OF PATHOLOGISTS**

**Date** December 1, 1973  
**Place** Indianapolis

## **INDIANA STATE NURSES ASS'N**

**Date** October 11-13, 1973  
**Place** French Lick

## **INTERNATIONAL COLLEGE OF SURGEONS**

**Date** December 1, 1973  
**Place** Indianapolis

## **INDIANA LUNG ASSOCIATION**

**Date** May 7-8, 1974  
**Place** Indianapolis

## **INDIANA THORACIC SOCIETY**

**Date** May 7-8, 1974  
**Place** Indianapolis

## **INDIANA STATE PODIATRY ASS'N**

**Date** Oct. 11-14, 1973  
**Place** Ramada Inn, Nashville

## **INDIANA PHILIPPINE MEDICAL ASS'N**

**Date** August 12, 1973  
**Place** Portage-For location and program inquire Anthony Recinto, M.D., 807 Chadbourne Drive, Indianapolis 46224



Editor: Frank B. Ramsey, M.D., 3266 N. Meridian Street,  
Room 705, Indianapolis 46208.

Associate Editors: A. W. Cavins, M.D., 75 Allendale Place,  
Terre Haute; Lall G. Montgomery, M.D., Ball Me-  
morial Hospital, Muncie; Samuel R. Mercer, M.D., 702  
Medical Center Bldg., Fort Wayne; I. W. Wilkens,  
M.D., 4820 E. Pleasant Run Pkwy, N. Dr., Indianop-  
olis.

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Assistant Editor: Jean J. Richardson  
Business Manager: James A. Waggener  
3935 N. Meridian, Indianapolis, Indiana 46208

## *Guest Editorials*

### **Top Banana Role for Hospitals?**

The American Hospital Association not only thinks there should be a "restructured system for the delivery of comprehensive health services" but seems to feel that hospitals should have the top role in bringing it to pass and in running it. Witness, in evidence, the following press release of the A.H.A.:

#### *Hospitals Told by AHA Board They Must Provide Leadership in Restructuring of Health Delivery System*

CHICAGO — The Board of Trustees of the American Hospital Association has called on the nation's 7,000 hospitals to take immediate action and leadership in order to make the necessary improvements in the present health care delivery system of the United States.

A "Statement on Hospital Responsibility for Leadership and Involvement in New Health Delivery Systems," which was approved at the last regular meeting of the 25-member Board, also states, "To accomplish the principle that health

care is a right, the Association has called for the development of a restructured system for the delivery of comprehensive health services. The implementation of the necessary improvements in the system requires immediate action and leadership by hospitals."

The document goes on to say that "The hospital, working with other health care providers, planning agencies and the community to develop a more organized system, must be the catalyst in assisting the community to determine its health care needs; bring together providers, planning agencies and community groups to determine how best to meet those health needs, and effecting proper improvements in the most expedient manner."

The AHA Board, in its statement, says that even though there have been significant advances in medical science and provision of health services, many major problems still persist. The Association cites in particular the maldistribution of facilities and services, deficiencies in the accessibility to services, fragmentation and duplication and rising costs.

Because of these problems, and others, hospitals must reassert their primary role in meeting the health care needs of the community, the

Board states.

According to the Board document any changes in the health care delivery system must: "... assure the availability and accessibility of quality care services in the most effective and economical manner; promote and build upon those elements of the present system that have proven to be effective, and include participation by providers and affected consumers in the planning, development and implementation of these changes."

It's a wry commentary on the intellectual visibility of the news release that it doesn't even mention doctors, although one presumes that hospitals will deign to include us with the "other health care providers" they will "bring together." The American Hospital Association would be better advised to get off its high horse of thinking that hospitals are the pivot around which everything concerned with medical care should turn. It would be hard to conceive of anything more disastrous to the cause of good, comprehensive health care delivery at reasonable cost.

Perhaps, if the A.H.A. kept certain realities in mind its advice to its member hospitals would be more sensible. For example, to call on hospitals to "reassert their primary



role in meeting the health care needs of the Community" is pretty close to fantasy. Doctors have always had and should continue to have the primary role—in their offices and in their other workshops—the hospitals. Another reality that the hospitals should face is that the concept that a "restructured system" of health care delivery is needed is figmentary. Improvements—yes; restructuring?—Who says so? And on what evidence?

And since when are hospitals of all possible agencies peculiarly qualified to dispose of such matters as "maldistribution of facilities and services, fragmentation and duplication and rising costs"? The experience of hospitals in such matters is either non-existent or lamentable to say the least.

We'll go along with A.H.A. when it proposes to "promote and build upon those elements of the present system that have proven to be effective." We can also agree that providers and affected consumers should participate in the planning, development and implementation of any changes that may be needed. But let's not forget what the ball game is all about in the last analysis—health care for individual patients delivered by doctors. If the A.H.A. keeps this overriding reality in mind, it will have the salutary effect of dissipating any burgeoning ambitions for systemized hospital control of medical care delivery. The result could be a "restructured" and constructive A.H.A. attitude and role, which would then, hopefully, rub off on its member hospitals.—**Alfred P. Ingegno, M.D., editor, *Bulletin, Medical Society of the County of Kings, Brooklyn, N.Y., April 1973.*** Reprinted with permission.

## Take Two Chicken Soups and Call Me in the Morning

Back in 1943 when I was in the third grade at P.S. 95 in Brooklyn,

I had a history teacher called Miss O'Connor who, although she was 70 years old, was one of the toughest, meanest old bastards that ever lived. Miss O'Connor's method of teaching me was to rap my head against the blackboard daily. Miss O'Connor may have been tough but she was also one heck of a history and civics teacher.

And I thought about her the other day when I read Senator Gaylord Nelson's most recent headline-grabbing statement. It seems that the Senator is investigating the cold and cough medicine business. I shouldn't say he is investigating because, if Miss O'Connor taught me correctly, when a United States Senator investigates, he first gathers all his facts from all sides and then, after careful deliberation, his committee reaches a decision and issues a report. Now I'm sure that if Miss O'Connor were around today she would take Senator Gaylord Nelson's head and bang it against the first available blackboard.

Because Senator Nelson apparently is going about his investigations ass backwards. He first issues a statement and then he gets around to investigating to see whether or not his statement is correct.

He recently opened up his "impartial" hearings by saying that the promotion of over-the-counter drugs is "nothing short of scandalous." He also said that "these products are, at best, mostly useless, while many are harmful and even dangerous." He also said that "most drug companies' promotion and advertising of these products is simply a generous mixture of false claims and outright nonsense." After making his opening statement, Senator Nelson started his "fair" and "impartial" hearing. This is the equivalent of a judge at a murder trial issuing a pre-trial statement to the jury to the effect that the accused is a murderous, assassin-type skunk and then proceeding with a "fair trial."

One of the first people Gaylord Nelson called to testify is a man who I think qualifies as the doctor of the year. His name is Dr. Sol Katz. Dr. Katz stated that of all the medicines available in this world the best treatment he knew for a cold is soup. Hot soup. What we have here in Dr. Katz is not your usual "take two aspirins and call me in the morning" type doctor. No, sir. What we have here is the most unique doctor that ever lived. Can you imagine going to see Dr. Katz with your head throbbing and your nose stuffed, with your mouth coughing and tasting foul and good old Dr. Katz, after giving you a complete examination, looks up and says, "You've got a terrible cold there."

You, the patient who can hardly breathe, reply, "I know I got a code, Dr. Kad, but whad cad I take for id?" "Split pea soup," replies the doctor. "Splid pea soup?" you reply in astonishment. "Yes, Campbell's has a sale on splid pea soup, er, er, I mean split pea soup. That's my prescription. And, since the soup only costs 35¢ and since the advice I gave you you could've gotten from your Jewish or Italian grandmother, suppose you give me \$1.25 and we'll call it even."

Of course, our nation's doctors, young and old, will soon adopt Dr. Katz as their hero. And patient after patient will try to cure their illnesses with soup. And soon there will arise great controversies in the medical profession as to what soup is more effective. And some doctors will back split pea soup and another group of doctors will say chicken gumbo.

Then, of course, there will be those radical young doctors who will say forget hot soup, try cold soup. And they will prescribe vichyssoise. And the Latin-American doctors will try to cure cancer with gazpacho. And then one day all the drug companies will be dead and out of business. And in Camden, N.J., the



Campbell Soup plant will have become more important to medicine than the Mayo Clinic. And on that day, sometime in 1990, good old Senator Gaylord Nelson, now about 75 years old, will look around for another group of people to persecute and some more headlines to grab. And he'll settle on the soup people and make headlines and some hack doctor will stand up and say that soup is overrated as a cure and if you have a cold and are feeling sick and miserable, he recommends a cure which consists of a bowl of cough drops. And the whole mess will start over again.

And so to Dr. Katz and to Senator Gaylord Nelson I address this column with an old Jewish/Italian curse—"May you both have a thousand colds and just one can of Campbell's Chicken Soup between you."—**Jerry Della Femina, Madison Avenue, February 1973. Reprinted with permission.**

## Editorial Notes...

**The Veterans Administration is hiring former addicts for work in its hospitals. Most employers will not hire former addicts unless they have good references and work records.** Most former addicts, naturally, do not have these qualifications. At least not until the VA adopted the policy of hiring selected good risks. The VA Hospitals are involved in rehabilitating many addicts and are able to predict when an addict is far enough along to be hired for hospital work.

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**Internships have been traditional-**

**ly accomplished by pharmacy students by service in retail or hospital pharmacies.** The pharmaceutical industry has established an alternative. Various pharmaceutical manufacturers are establishing educational programs for students with emphasis on training opportunities as contrasted to the type of experience acquired in a temporary summer job with the industry. The internships will be concerned with many phases of industrial work such as production, quality control, research, marketing, medical department affairs and health economics.

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**The National Society for Medical Research reports that investigators in San Antonio have found that removal of the pineal gland in rats also removes any desire of the animal for alcohol ingestion.** More work is scheduled to determine the mechanism.

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**Research at the University of California at Davis shows that amniotic membrane, which is obtained from unborn lambs, may be used to great advantage as temporary dressing for surface wounds and burns.** The material remains alive up to eight days, tends to prevent infection, relieves pain and allows healing to take place. The National Society of Medical Research thinks that the membrane may become an item of conventional use if research findings continue to indicate these advantages.

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**Dr. Phillip Walker of Vanderbilt criticizes the Social Security disability payment system by noting**

**that the system "financially punishes the man who attempts to work despite his disability."** Dr. Walker advocates that partial Social Security or other public support be provided to the patient who can work part time.

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**Accidents in and about the home took 27,500 lives in the U.S. last year, about 2000 less than in 1966.** Even though the home accident rate has decreased steadily for the past five years, it is still too high and largely preventable. Fatalities are considerably more frequent among males, despite the shorter time the male members of the household are actually at home. Falls, fires, and poisoning are the three most frequent causes.

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**It is reported that a high school in Massachusetts, with the best of intentions, showed a documentary film about drug abuse, complete with details.** The students were impressed. They asked for and got a reshooting. This was followed by an increase in mainlining. The incident has caused the "experts" in the drug field to change tactics.

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**Psychiatric and drug dependence patients are working for business firms as paid employees, but do their work in the workshop of the Palo Alto VA Hospital.** Patients also operate four nearby service stations. The work is primarily therapy, but adds skills to help veterans get jobs after release. The work is paid for by the cooperating business firms. ◀

## About Our Cover

The Journal is honored to present a reproduction of an original painting by Wei-Ping Loh, M.D., Gary pathologist, whose "Peace" painting was featured on our July 1972 cover.

The painting commemorates The Year of the Ox, which this is on the Chinese calendar.



# ISMA Launching Accreditation Plan

**F**OLLOWING is the text of a letter sent to all hospitals, and other institutions and organizations in Indiana currently engaged in continuing medical education for physicians.

The ISMA Accreditation Committee is publishing the letter in the Journal for the information of the ISMA membership.

"The Council on Medical Education of the American Medical Association has provisionally approved the Indiana State Medical Association's continuing education accreditation plans for one year. As they and we gain more experience, full accreditation can be expected if we implement our present plans. Essentially the program that has been developed stems from the ISMA's action in 1971 directing that we develop an accrediting program for continuing medical education. This program is in conjunction with the AMA, their Physician Recognition Award program, and all interested professional and educational organizations within the state. The primary role is in direct patient-care educational programs.

"To insure that activities will pro-

vide meaningful educational experiences to the physician, the Commission on Medical Education and Licensure has set up minimal standards for institutions and organizations desirous of such accreditation. The Commission has adopted totally the American Medical Association's "Essentials of Approved Programs in Continuing Medical Education" Evaluation of the effectiveness of continuing medical education should be an integral part of every program.

"Doctors attending these accredited programs may qualify for the AMA Physician's Recognition Award as well as the recently approved Indiana Award for Continuing Medical Education and awards offered by other organizations requiring continuing medical education. Qualified institutions or programs will be granted an accreditation certificate from the Indiana State Medical Association. A minimum of 150 hours for three years of continuing medical education is required.

"If your organization feels that it wishes to become an accredited teaching source, please let the ISMA

know. The process of accreditation will consist of a detailed questionnaire which will serve as an inventory of your resources. When this is completed and received, a site visit team will meet and discuss in detail your plans. The ISMA will then be in position to give their accreditation. There will be annual reviews of the various programs. An appropriate charge will be made by the ISMA commensurate with the amount of work involved in the survey.

"Programs would include courses, activities, lectures, rounds and any component of a continuing medical education plan in an institution or organization or in a combined sponsorship by any of these groups. Please note that the survey team of the Indiana State Medical Association is primarily concerned with continuing education of the medical staff and with physicians of the community and not with house staff education, fellowships, or student training programs.

Sincerely,  
Eugene M. Gillum, M.D.  
Chairman  
ISMA Accreditation Committee"

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# Physician-Need in Indiana: A Survey and Its Results

JOHN C. JOHNSON, B.A.  
Indianapolis

INDIANA needs more physicians. This fact has generated much action:

1. Indiana licensing laws have been eased with regard to reciprocity to attract licensed out-of-state physicians to Indiana.<sup>7</sup>
2. Indiana has legislation to "retain and attract more physicians" to the state.<sup>4</sup>
3. Medical school enrollment in the state has increased 23% in the last five years and 54% in the last 22 years. (Note: Presently there are 290 freshman matriculants and a total of 1,042 medical students enrolled. The national average enrollment of medical schools is 416.)<sup>5</sup>
4. Of the present 290 freshman medical students, 31.4% are now studying in seven cities other than Indianapolis (Bloomington, Evansville, Gary, Lafayette, Muncie, South Bend, and Terre Haute).<sup>5</sup>
5. Senior medical students have the opportunity to study elsewhere with 94% of the present

senior class participating in these off-campus electives. Over 50% of the present senior class is in off-campus, Indiana-based senior elective programs involving 56 community hospitals and more than 140 physicians.<sup>5</sup>

6. Internships and residencies in Indiana have increased 55% since 1967. (In 1967 there were 117 interns and 311 residents in Indiana located in only two cities. These figures have increased to 160 interns and 504 residents in six cities for 1972 with even further increases expected for 1973. (Note: Only 8% of these post-graduate experiences were filled by foreign medical graduates in Indiana in 1972. Nationally this figure is 33%.)<sup>5</sup>
7. Continuing education courses have been increased substantially.<sup>5</sup>
8. The General Assembly funded the Indiana Statewide Medical Education System in April 1971 to increase the number of physicians and the quality of medical care in Indiana.<sup>5</sup>
9. And, perhaps most importantly, the retention of Indiana medical students for internships and residencies has increased from 44% in 1963 to 55% in 1972.<sup>5</sup>

But the fact remains, Indiana needs more physicians.

In 1970 Indiana nationally was

tied for fortieth place based on its physician-to-population ratio with 103 physicians per 100,000 population while the national mean was 146 per 100,000.<sup>5</sup> For 1971 this figure for Indiana was 103.2 per 100,000 with a projection of approximately 105 per 100,000 for 1972, placing the state approximately thirty-fourth nationally. Although this is a 6.4% increase for the last 12 years, it still ranks Indiana far below the national mean.

Nationally as well as in Indiana the physician shortage is greatest in the area of Family Practitioners.<sup>6</sup> If one looks at the national physician-need, the great majority of this need is in the area of Primary Care Physicians (Family Practitioners, Internists and Pediatricians). This, too, is the case for Indiana.<sup>6</sup>

## The Problem

The problem appears to be three-fold:

- a. Indiana does not have enough physicians.
- b. Indiana does not have the proper geographic distribution of physicians.
- c. Indiana does not have the right type of physicians (by specialty orientation).

The first segment of Indiana's physician-need problem is being solved. Since 1907 Indiana University School of Medicine has graduated 7,063 physicians.<sup>5</sup> By 1982 an additional 3,161 physicians will graduate, of which 1,021 would

Abstracted from a report by John C. Johnson. A copy of the full report, including a copy of Table I, may be obtained from *The Journal* on request. Table I is a tabulation of the questionnaire returns by counties and cities.

Mr. Johnson is a fourth year medical student at the Indiana University School of Medicine, Indianapolis.



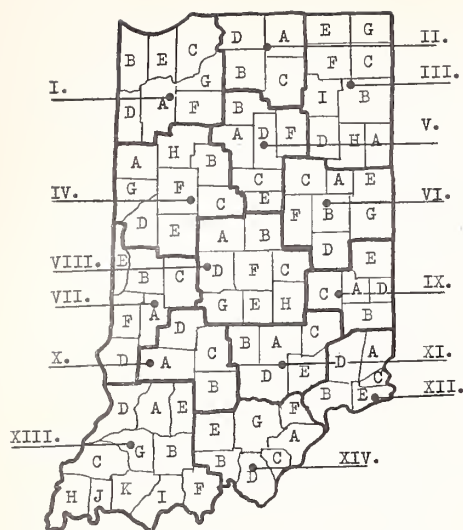


FIGURE 1  
Indiana Regions and Counties (as utilized in Table 1).

not be available if it were not for the Indiana System for Statewide Medical Education.<sup>5</sup> In the spring of 1977 Indiana University will graduate at least 290 physicians, an increase of 23% over 1973, as compared to a projected state population increase of 4% for the same period.<sup>5</sup>

The second segment of Indiana's physician-need problem is geographic in nature. In the 1974 graduating class at Indiana University over 30% of the 249 students in the class are actively considering a future in Family Practice. More than half these students are presently convinced that they will remain in the state of Indiana. However, one question which frequently arises among groups of students is *where* to practice.

The third segment of Indiana's physician-need problem is more complicated and can be divided into at least two subsegments:

- a. Indiana medical graduates do not know what Indiana as a whole and what communities individually need in the way of medical specialists.
- b. Indiana medical graduates, as do all physicians, choose their area of specialization based on personal preference.

With the number of physicians needed being provided, it appears that **communication** is one of the biggest problems affecting Indiana's physician-need.

### A Plan

In the winter of 1972 a plan was put into effect to pinpoint the areas of physician-need in Indiana and to establish the needed communication. A letter was drafted pointing out the fact that most medical graduates do not know where to practice.

Accompanying this letter was a form requesting a brief community profile (population, area characteristics, income level, income source), a brief medical profile (type of medical facilities available, number of practicing physicians), the number of physicians needed to meet the area's estimated needs, and the type of physicians needed. In addition, the individual returning the form or someone in the community was requested to serve as a source of further information for students, interns, residents or practicing physicians. This letter and accompanying form were mailed to 4,304 physicians in the state of Indiana, 214 service clubs (primarily the Chambers of Commerce), and five towns known to have a specific need.

### Results

There has been a 13% (545 letters) return representing 91.3% of Indiana's counties. The results are summarized in Table II.

In a broad sense this survey has confirmed what was already known: Indiana needs more physicians. In fact, Indiana needs at least 756 physicians, 57.4% of which are desired as Family Practitioners. And 73.3% of Indiana's physician-need is in the area of primary care. We now not only know how many and what type of physicians the state of Indiana needs; more importantly,

we know where these physicians are needed.

### Discussion

Although the return is only 13%, this represents 91.3% of the state's counties with a good geographical distribution of cities within these counties and within the state as a whole. Based on the information tabulated in Table II, this survey can be considered to have fulfilled its design. This survey measures what each town—utilizing the opinion of its local physicians (primarily) and service clubs—feels it needs in the way of additional medical services as administered by physicians.

Unfortunately, this survey is biased in that the majority of the mailings and the majority of the returns involved physicians. Perhaps in the future, after some degree of education as to health care practices and community awareness, the lay (non-medical) public may be surveyed as to the medical needs for their communities.

The reason for the 8.7% failure in county returns is not known. One could speculate that these counties could see no reason to respond since they all had populations less than 17,200; however, 15 (71.4%) of the 21 counties in Indiana with populations less than 17,200 did respond. Perhaps they did not respond because they do not have a hospital; but 11 (69%) of the 16 counties without a hospital did respond. And they all have physicians (at least one) who should have received a letter. The reasons for the 87% failure in individual returns will surely prove to be multiple and will not be discussed.

Although the number of responses varied from one to twenty per town, the average was three per town and the correlation among returns for a given town was remarkable in light of no apparent collaboration in completion of the

Table II. Summary of Indiana's Physician-Need

Region	No.	ret	mds	FP	IM	PED	GS	OB	ORT	OP	OT	oth <sup>a, b</sup>
I		65	137	83	11	9	6	2	2	4	6	14
II		52	72	33	7	6	5	4	5	4	1	6
III		73	87	50	8	6	3	4	1	3	0	12
IV		30	44	24	6	3	0	0	3	1	2	5
V		36	40	23	3	3	3	1	2	1	2	2
VI		53	66	36	4	6	4	4	4	3	4	1
VII		30	36	20	2	2	4	1	1	2	0	4
VIII		57	74	50	4	6	4	2	1	0	3	4
IX		22	25	12	2	1	1	1	0	1	1	6
X		20	27	12	2	4	1	3	2	0	0	3
XI		22	26	11	3	2	2	1	2	0	1	4
XII		12	14	11	1	1	1	0	0	0	0	0
XIII		50	81	48	11	4	3	3	2	1	1	8
XIV		25	29	21	2	2	1	1	2	0	0	0
Totals	=	545	756	434	66	55	38	27	27	20	21	69

<sup>a</sup>Explanation of abbreviations:

ret: The number of completed and returned Physician-Need Forms per areas designated.

mds: The number of physicians calculated to be needed per area designated based on the need of that area as shown on the returned Physician-Need Forms.

A breakdown of the physicians needed (see "mds," above) into the following specialty groupings: FP (Family or General Practice), IM (Internal Medicine; does not include the subspecialties of IM), PED (Pediatrics), GS (General Surgery; does not include the subspecialties of GS), OB (Obstetrics and Gynecology), ORT (Orthopaedics), OP (Ophthalmology), OT (Otorhinolaryngology).

<sup>b</sup>Summary of specialties or subspecialties listed as "oth":

Allergy — 1	Plastic Surgery — 1
Anesthesiology — 1	Psychiatry — 12
Cardiology — 3	Radiology — 4
Dermatology — 3	Renal Medicine (Nephrology) — 1
Hematology — 2	Research — 3
Neurology — 11	Rheumatology — 1
Neurosurgery — 5	Urology (genitourinary) — 8
Pathology — 3	

forms. Even when comparing the physician and the lay returns it is apparent that communities are very cognizant of their medical needs (or at least evaluate their needs using the same criteria, be they valid or not).

### The Future

In addition to providing the numbers which comprise the tables in this article, the forms returned in this survey have a more important function: they provide students, interns, residents and physicians a reference to use when trying to decide **where** to practice in the state of Indiana. These forms provide a link between medical graduates and Indiana communities. The forms have

been photocopied and filed alphabetically by town name and also by the type (specialty area) of physician(s) needed. In addition, brochures, pamphlets, photographs, statistics and information other than that contained on the one-page official physician-need form which have been provided by the towns responding to this survey have been filed separately by town name. And, these forms contain the names of individuals (medical and non-medical) in the towns responding who may be contacted for further information.

These volumes of data are available for inspection by **any** individual desiring more information on In-

diana's physician-need. Through this article and "advertising" on the Indianapolis and regional medical center campuses and hospitals throughout the state, it is hoped that medical students, graduates, and other interested persons will be aware of these data and will utilize them in choosing where to practice in Indiana.

Based on discussions among those who participated in the April 7-8, 1973, Student - Faculty - Physician Retreat, a formal program to help communities become more attractive to medical students and medical graduates and to help these students and graduates to find Indiana communities in which to practice



is very likely to become a reality in the near future.

### Summary

The state of Indiana needs at least an additional 756 physicians. Of these 756 physicians, 73.3% are needed in the area of primary care medicine.

Now for the first time it is known where the people of Indiana feel they need more physicians. This small but vital understanding will help greatly, for with this understanding and continued public interest and public action, along with the many strategies already in effect, the state of Indiana will correct its physician-need.

### Acknowledgement

I would like to express my sin-

cere appreciation to Glenn W. Irwin, Jr., M.D., dean, Indiana University School of Medicine; James E. Carter, M.D., associate dean for Student Affairs; Steven C. Beering, M.D., associate dean; H. Ronald Gines, administrative assistant to the dean; the secretarial staff of the dean's office; and to my wife, Linda, for their spiritual, physical, and financial support of this project.

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**DESCRIPTION:** Methyltestosterone is 17 $\beta$ -hydroxy-17-methylandrosta-4-en-3-one.

**ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone.

**INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

**PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

**CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

**WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration of excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued.

**ADVERSE REACTIONS:** Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

**DOSEAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.

INDICATION	Average Daily Dosage Tablets
In the male:	
Eunuchoidism and eunuchism	10 to 40 mg.
Male climacteric symptoms and impotence due to androgen deficiency	10 to 40 mg.
Postpubertal cryptorchidism	30 mg.

HOW SUPPLIED: 5, 10, 25 mg. in bottles of 60, 250.

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## Bloomington Physicians Offering Free Health Care

**A**N unusual medical care program for the working poor in Monroe County is now a reality.

Ongoing health care will be provided to 300 families in the Monroe County area by local physicians and other medical services without charge, according to Dr. Harold Manifold, chairman of the Society's committee which has drawn up the plan in a joint effort with the Monroe County Community Action Program.

The families involved are those who have income but are the "in-between" group where no services are available from public or private sources for medical care.

Handling the administration and

conduct of the program is a Health Services Bureau, which will serve as a research and screening agency for families who wish to qualify for the program.

Basic to qualification are current residence by the family in Monroe County, no other available means for continuing health care, more than half their net income spent on food and housing, receipt of a family income based on a scale of dollars and family size, and not be voluntarily poor.

Physicians will treat and maintain records on these patients on the same basis as all other patients, with referrals, when needed, to specialists

who will also provide free service. All patients, under the plan, will be assigned to primary care physicians.

Supportive services will be provided by the Bloomington Hospital, Southern Indiana Radiologic Associates, Monroe County Pharmaceutical Association and the Indiana University Speech and Hearing Clinic.

Volunteer registered nurses on a regular schedule will monitor family status and needs, check to see that the family understands and follows the physician's recommendations and provide health education and ancillary services recommended by physicians. ◀

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## TEXTBOOK OF PATHOPHYSIOLOGY

W. D. Snively, Jr., M.D., and Donna R. Beshear, J. B. Lippincott Co., Philadelphia, 1973; in two parts comprising 21 chapters, 410 pages; \$10.75.

Doctor Snively and his most able collaborator have just about succeeded in pulling a rabbit from the hat! From the outside—and at first scanning—this looks like an elementary textbook aimed at the lowest rung of the medical learning ladder. The type is large; the chapters seem to be brief to the point of mere summations of single sentences; the “Topics for discussion” appear to be just the kind that the students would debate with their instructors—almost *too* pat for the format!

And yet, as I began to read seriously I was absolutely delighted to find that the *substance* of the subject was being offered with a maximum of clarity, in depth, and with the irreducible minimum of words! And that, Ladies and Gentlemen, became such an unalloyed delight that I plowed through the entire volume, skipping nary a page! And I think that I was able to glean bits of information, here and there, that were news to me!

Surely, the authors of this unpretentious text have given a maximum of service for the merest trifle of a price. Try it; you'll like it, too!

ARNOLD LIEBERMAN, M.D.  
New York

## CURRENT DIAGNOSIS AND TREATMENT, 1973 EDITION

Marcus A. Krupp, M.D. and Milton J. Chatten, M.D., Lange Medical Publications, Los Altos, California, soft cover; 996 pages; price \$12.00.

With the help of 34 other authors, chiefly colleagues from Stanford University School of Medicine, University of California and other schools of medicine of the West Coast, Drs. Krupp and Chatten have gotten together an extremely useful volume. Because the material is condensed, it is neither a comprehensive text on pharmacology or on differential diagnosis. However, for the physician in active practice who already has a grasp of the fundamentals of his particular field, it will prove a very practical and useful volume. The disorders commonly encountered in the practice of Internal Medicine receive the most space in the book, but there are chapters on diseases of the eye, the nose and throat and the genito-urinary system, as well as consideration of the diseases in which genetic, immunologic and neoplastic aberrations are chiefly concerned.

There has been a yearly edition of this volume since 1962. The 1973 edition will be available in the native languages of Mexico, Romania, Serbia, Portugal, Germany, and Japan.

The material is not presented in cookbook style. Enough information regarding the diseases being dealt with is given so that the rationale of the remedies suggested is understood. When the pathologic physiology is complex—such as in immunologic disorders, sufficient references are given to enable the reader to pursue the subjects in more depth, if he chooses. But the outlines of treatment of most diseases and discussion of drugs and antibiotics is extensive enough usually to make further reading unnecessary.

This reviewer was glad to see a good discussion of possible deleterious side effects of commonly used drugs in pregnancy. Also, a very up-to-date discussion of antineoplastic therapy (a field changing rapidly, year to year) is given. Taken altogether, it is a book of immensely practical value, which should find a place in the library of every physician who is treating patients.

PAUL S. RHOADS, M.D.  
Richmond

## SUICIDE PREVENTION IN THE 70s

Resnik, H. L. P., and Hathorne, B. C., editors, Rockville, Md., National Institute of Mental Health, 1973.

*Suicide Prevention in the 70s* is an authoritative monograph on the enormously important problem of suicide in present-day United States. It reports the results of a conference held by a task force of some 50 leaders and students in the fields of suicide prevention, self-destructive behavior, and dying and bereavement, assembled for three days in Phoenix, Arizona, January 1970. In addition to reporting the results of the conference, the monograph makes use of the assembled experts to plan a comprehensive curriculum in suicide studies. The resulting curriculum was subjected to pilot testing and evaluation in 1971. Revised, it is now available on a general basis. *Suicide Prevention in the 70s* includes such topics as classification and nomenclature, self-destructive behavior, training in suicidology, research in suicide, suicide and crisis, intervention services, and priorities for improved treatment approaches. This monograph is strongly recommended for those interested in suicide prevention. It is available as DHEW Publication No. (HSM) 72-9054, U.S. Department of Health, Education, and Welfare, Health Services and Mental Health Administration, National Institute of Mental Health, Rockville, Md. 20852.

W. D. SNIVELY, JR., M.D.  
Evansville

## IS MY BABY ALL RIGHT?

Virginia Apgar, M.D., M.P.H., and Joan Beck, Trident Press, New York, 1972; illustrated by Ernest W. Beck; 492 pages, including index; \$9.95.

This book is most unusual in that it is scientific in viewpoint and content, yet is presented in a manner which should be comprehensible to any high school graduate. Furthermore, there is not the usual attempt to glamorize the subject or to use some of the journalistic tricks so often employed when a newspaper writer collaborates with a medical authority. Virginia Apgar needs no introduction to physicians, especially obstetricians, and Joan Beck writes a syndicated column and is on the staff of the *Chicago Tribune*.

The illustrations, both pictures and diagrams, are excellent, and most of them should be easily understood by anyone who



is literate. For the layman, this work should be an eye-opener, and for the physician it is an excellent review of many things he has forgotten in embryology and of some of the recent discoveries in genetics.

Internes and residents should read this book, especially those in pediatrics, obstetrics, and gynecology, as it will reveal to them the typical reactions of parents and prospective parents to the various situations and problems involved in parenthood as affected by birth defects.

In addition to this, the busy physician interested in counseling patients with "unwanted" pregnancies should find it helpful to have the woman read Chapter 3, at least pages 48-65. Facts are presented here in a matter-of-fact way, and in sufficient detail to give any such woman the information she needs to comprehend what an abortion entails as far as the conceptus is concerned. This she should know and it should be imparted to her without bias, as in this book. Otherwise, sooner or later she will recognize the bias, if any, with consequent loss of confidence plus psychological damage. Read Chapter 3 yourself, and you will get the point immediately.

The explanation of chromosomes, genes, and the mechanisms of heredity is both clear and fascinating. It is presented in such a way that what we do not know does not detract from what we do know in interest and application—a first-rate accomplishment. Birth defects are described under 25 different headings or classes, some with a single subject—such as hemophilia or diabetes—and others with multiple facets—such as mental retardation. There is some overlapping of categories, as for instance, the inborn errors in metabolism include diabetes, yet the latter is so important it is given a separate chapter and elaborate discussion. The chapter on minimal brain dysfunction is one of the best and also one of the most important, because of the frequency of this disorder, found in 7 to 7.5% of school children. The proper separation of this condition from the emotionally disturbed child benefits not only the child, but can relieve the parents greatly from feelings of guilt and confusion in self-assessment of their conduct toward the child.

There are chapters on Rh disease, PKU, and rubella, which are excellent, especially the illustrations diagramming Rh situations. A short chapter on syphilis is not only timely but, again, *presents facts* which the unwary would do well to read.

Chapter 31 on "How to Prevent Birth Defects" is intended to relieve with general remarks some of the tension built up in preceding chapters, but its real value is found in 17 specific recommendations to pregnant women concerning their conduct during pregnancy. Finally there is Chapter 32, on genetic counseling, followed by "Sources of Help"—a list of private and government agencies concerned with birth defects.

This is a well conceived, well written and well printed book, well suited, in this reviewer's opinion, for the general public, for whom it is intended, but certainly valuable and of great interest to any physician, especially one who works with children in any capacity.

A. W. CAVINS, M.D.  
Terre Haute

## VASECTOMY, SEX, AND PARENTHOOD

Norman Fleishman and Peter L. Dixon, Doubleday & Co., Inc., Garden City, N.Y., 1973; 128 pp; \$5.95.

Vasectomy operations in the last two or three years must number hundreds of thousands, and this octavo-sized, hard

cover but inexpensively printed book is written for the man who contemplates the surgery but is unsure of his decision and who desires further knowledge of the details. There is a foreword by Alan F. Guttmacher, M.D., who is associated with the "Planned Parenthood World Population" group and the book is frankly advocative in favor of vasectomy as the best and the ideal, permanent method of contraception.

There are sections explaining the procedure and humanizing the experience in terms of the authors' own vasectomies and why they were done. Emphasis is placed (and rightly so) on the difference between fertility and sexual potency and the point repeatedly made that potency might even be augmented by removing psychological barriers in the man's mind regarding causing an unwanted pregnancy. An appendix lists vasectomy clinics, organizations concerned with vasectomy, and sperm banks.

A need exists for promulgation of information regarding this widespread operation and the first part of the volume is useful. The authors are a little hard on the medical profession regarding fees and they state that no vasectomy should cost more than \$100. They also gloss over the newly discovered immune responses in the vasectomized man which must be weighed in the balance when deciding on permanent sterilization. Where this book annoys me is the frankly maudlin attitude regarding the effects of overpopulation. Now, I believe that there is such a problem, but after reading the story of the child in India who had her hands cut off by a master "Fagin" type so she can beg more effectively and relating this to the fellow who doesn't know whether to have a vasectomy or use a condom, then I hear axes grinding in the background. Chapter 9, "What the World Needs Now" is laid on thickly—it makes me think more of suicide than sterilization for the population explosion.

Finally, this is a book authored by a freelance writer and a professional population control executive and is intended for the public. These books for the layman sometimes irritate the professional reader and it is so in this instance. They exhort so unreservedly. The point that they make, however, that the world might be endangered by human overprocreation is very important and, to me, probably valid. The position that vasectomy is an unmitigated benefit is not tenable and I cannot recommend this book to my patients for that reason. The procedure of vasectomy is safe, relatively painless and inexpensive and many men may elect in good conscience to use this means of contraception. It will, nevertheless, take many years to know thoroughly the effects of sperm protein absorption on the human organism. The authors have an unfulfilled obligation to emphasize these facts to the reader.

RODNEY MANNION, M.D.  
Michigan City

## HANDBOOK OF PEDIATRICS, 10th EDITION

Silver, H. K., Kemp, C. H., and Bruyn, H. B.: Los Altos, California, Lange Medical Publications, 1973.

Lange Medical Publications has produced another winner in *Handbook of Pediatrics*. Doctors Silver, Kempe, and Bruyn have succeeded in their objective to present to the practicing physician and medical student a concise and readily available digest of the material necessary for the diagnosis and management of pediatric disorders. While stressing clinical aspects of the subjects covered, the authors have included pertinent summaries of physiologic principles and recent advances. The



## ABSTRACTS, BOOKS

Continued

book has some 700 pages sturdily bound in plastic. End papers provide useful information for the physician caring for children. Each clinical entity frequently seen in pediatrics, and many infrequently seen, are presented in succinct form. A useful appendix, pp. 603-666, presents information on drug therapy, normal values, chromosomal disorders, and differential diagnosis of certain common symptoms and signs. This well-named handbook is strongly recommended for all physicians seeing children.

Should additional information be required on pediatric diagnosis and treatment, this reviewer strongly recommends *Current Pediatric Diagnosis and Treatment* by Kempe, Silver, and O'Brien, also published by Lange Medical Publications.

W. D. SNIVELY, JR., M.D.  
Evansville

### BLAKISTON'S GOULD—MEDICAL DICTIONARY, 3rd EDITION

Arthur Osol, Ph.D., editor, McGraw-Hill Book Co., 1973; some 30-odd contributors; 1828 pages; 26 illustrative plates in color; well grouped tables and explanatory notes; over 75,000 terms defined.

It is startling to realize that the previous edition is dated 1957. Dr. Normand Hoerr, whom I knew well, inscribed that volume to me. As he died the very next year, I treasure that page and excised it carefully before pasting it into the present volume. From the outside, both volumes appear all but alike.

Yet, Medicine is moving along at an ever accelerating pace; many terms have become obsolete, many others are absolutely recent. Even a cursory scan of this compendium reveals the fact of the deletion of the obsolescent and the appearance of the new. The editorial board has done its task well!

The paper, binding and the type continue in their impeccable perfection. This dictionary is an absolute MUST for every practitioner of Medicine as well as the researcher in the Basic Sciences.

ARNOLD LIEBERMAN, M.D.  
New York

### TEACHING TROPICAL MEDICINE Clinical Tropical Medicine, Vol. 3

Edited by Kevin M. Cahill, University Park Press, Baltimore, 1973; \$11.50; 141 pages.

This impeccably assembled little volume is really a colloquy between the distinguished editor, Dr. K. M. Cahill, and his hand-picked half-dozen-odd fellow professors specializing in Tropical Medicine. They bring out clearly the great differences existing between the industrial nations and the undeveloped lands where tropical diseases as such are actually prevalent and in desperate need of being eradicated. Malaria, Sleeping Sickness, the Relapsing Fevers, Typhus, Yellow Fever, Kala-azar, Oroya Fever, Trypanosomiasis, Undulant Fever—you name them! They are still there!

There are many quotable phrases but I was particularly taken by Professor M. Yoelli (on page 40) paraphrasing the Talmud and saying "I believe that we should tell the story of tropical medicine in such a way that a student in his formative years, on leaving the lecture hall will say: 'I too was there!'"

The paper, binding and printing are splendid. The typographical errors are all but absent. Thus, on page 33, sixth line from the bottom, the word (most obviously) should be "teeming" and not "teaming." A trifle of no consequence!

I'm inclined to look for the volumes one and two and see how they compare!

ARNOLD LIEBERMAN, M.D.  
New York

### YOUR PROSTATE

Robert L. Rowan, M.D., and Paul Gillette, Ph.D., Doubleday and Co., Inc., Garden City, N.Y., 1973; 147 pp; \$5.95.

Many facets of medical practice are taken for granted as being too elementary for serious study by the practicing physician and yet at times it can be instructive to read a layman's manual. That is not true with this book because it contains urological fallacies which are difficult to attribute to "a specialist in the area of prostate diseases" as the dust jacket depicts Dr. Rowan. The other author is a Ph.D. who seems to have written a number of books popularizing medical topics.

Eight chapters, a Glossary and Index cover the subject and are written in clear English. Extra emphasis on sexual function assures the reader of the authors' modern approach. Incidentally, the new word for promiscuous is "varietistic" which obviously won't offend the most promiscuous of readers and is used in connection with all venereal prostate or urethral afflictions. This is innovative and, who knows, might be of practical value when dealing with patients with gonorrhea or syphilis. One cannot be too cautious.

The Foreword is a clever presentation which establishes the prostate as a "serious disease" but one which has been neglected by the news media and philanthropic foundations. The authors would like to correct this deficiency but, as is sometimes true with quasi-scientific journalism, errors of emphasis and fact are the main difficulty. The authors state that antibiotics enter the prostate (refuted by Thomas Stamey and associates<sup>1</sup>); that asymptomatic prostatic carcinoma categorically doesn't require treatment (Dr. Charles Huggins, our only urologist who is a Nobel Laureate, feels this may be "meddlesome"<sup>2</sup>); finally, they say that a radical prostatectomy removes only part of the prostate. This gaff is finally rectified in the "Glossary" but the name Huggins continues to be misspelled "Huggings" throughout the entire text. Could a trained urologist have failed to catch this in the galley proofs? It is doubtful.

The public deserves to know more about the prostate and its diseases than the oldtime advertisements used to contain in pulp magazines but the mistakes here cannot be excused. Don't recommend the book to your patients because it is not worth the price asked.

RODNEY MANNION, M.D.  
Michigan City

1. Stamey, T. A., *J. Urol.*, 104:559-563, Oct. 1970.
2. Huggins, Charles, *J. Urol.* Editorial.

### ADVANCES IN BIOPHYSICS

Masao Kotani, editor, vol. 3, University Park Press, Baltimore, 1972; 280 pages; six original articles by Japanese biophysicists; Intended also for closely related disciplines such

as physiology, biochemistry, etc.; \$14.50.

In their accustomed thorough and painstaking fashion, the Japanese authors discourse most logically and clearly on such topics as: "Actions of Transmitter Substances on the Neuro-muscular Junctions," "Theoretical Studies on Hemorrhology," "Primary Processes of Insect Chemoreceptors," "Evolution of Cytochrome C Molecule," etc. The tables and charts are very clear; the differential equations cannot be faulted (at least by this reviewer); the amino acid sequences appear flawless: the whole bit seems a splendid addition to the international literature.

It is truly heartwarming to witness so rapid an appearance of literature from a distant clime on research still in progress! However, this volume is truly for the expert in the specialty concerned. In all candor, I must confess that the usual M.D. and even the graduate student in the sub-specialties under discussion needs to be *truly* an expert to be in a position to read and genuinely benefit from the virtuoso performances presented for his delectation!

The binding, printing and paper are superb and the price is a mere piddling nothing for what is being offered!

ARNOLD LIEBERMAN, M.D.  
New York

REHABILITATION MEDICINE

Howard A. Rusk, M.D.,—3d edition, C. V. Mosby Co., St. Louis, 1971; \$23.50; 687 pages in 31 chapters, with numerous illustrations and charts; at end of each chapter there are updated bibliographic references.

It is almost impossible to retain total objectivity when confronted by the third edition of the magnum opus of a truly great man who is already a legend in his own time. A Charcot, an Osler, a Freud, a J. B. Herrick, a Whipple—how often do such persons destined for immortality come along? It is no secret that—in this second half of the 20th century—Howard A. Rusk has already accomplished more than enough to be, almost automatically, already a member of this super-select, rare band!

Of course, I cheerfully admit to being prejudiced! After all, it was he who helped me most directly to overcome completely the nasty physical handicaps sustained in an egregious accident many years ago.\*\* He has that rare combination not only of human compassion and understanding but also the phenomenal capacity for the endless tasks required to organize a brand new sub-specialty and developing an enormous institute putting his ideas into solid, everyday practice. He is all but prescient in choosing his associates and guiding them into just the right daily performances of their burgeoning tasks.

It goes without equivocation that this present volume is absolute must reading, not only for those directly in the field of rehabilitation but also just about for *every* physician or paramedic who should learn what can be done in cases formerly shrugged off!

Finally, it is no minor afterthought to apprise the reader of the fact that Dr. Rusk (who is working with unflagging zeal long after having attained the age of retirement) has just published an autobiography (already on the best-seller list)

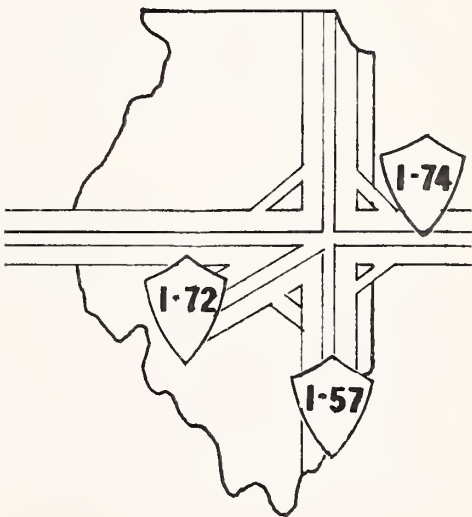
\*\*See Introduction to *Case Capsules* (by yours truly). Prologue written by Dr. Howard A. Rusk.

Continued

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## ABSTRACTS, BOOKS

Continued

with the rather modest title "*A World to Care For.*" All literate people should peruse it, many times.

ARNOLD LIEBERMAN, M.D.  
New York

### Abstracts from Various Literature, Prepared by AMA

#### GALLBLADDER DISEASE AND THE HEART

P. M. Brooks and R. Cutforth (Cardiac Investigation Center, Hobart, Tasmania)

*Med. J. Aust.* 1:340-342 (Feb. 17) 1973

Fifty patients who underwent surgery for gallbladder disease took cardiac stress tests before and two months after surgery. Fourteen patients showed evidence of preexisting coronary heart disease (CHD) and this was unaltered by the operation. Squeezing the gallbladder during surgery provoked arrhythmias in six of ten patients with CHD and in two of 14 of those without demonstrable heart disease. Removal of a diseased gallbladder may decrease the arrhythmia potential, particularly in patients with associated CHD, but does not alter the angina threshold.

#### VIGOROUS EXERCISE IN LEISURE-TIME AND INCIDENCE OF CORONARY HEART DISEASE

J. N. Morris et al. (London School of Hygiene and Tropical Medicine, London)

*Lancet* 1:333-339 (Feb. 17) 1973

A total of 16,882 male executive-grade office workers aged 40 to 64 recorded their weekend activities on a questionnaire on habits and personal history; 232 of the men have since suffered a first clinical attack of coronary heart disease (CHD). In men recording vigorous exercise the relative risk of developing CHD was about one third that in comparable men who did not, and in men reporting much of it still less. Lighter exercise and provisional estimates of overall activity showed no such advantage.

#### CELL-MEDIATED IMMUNITY IN PATIENTS WITH OVARIAN CARCINOMA

S. Y. Chen et al. (D. Koffler, Mount Sinai School of Medicine, New York 10029)

*Am. J. Obstet. Gynecol.* 115:467-470 (Feb. 15) 1973

Eight patients with serious or mucinous cystadenocarcinoma were tested for cellular hypersensitivity to tumor antigens by a leukocyte migration test. Inhibition of leukocyte migration with autologous tumor was noted in all patients. Leukocytes from five of seven patients studied showed cross-inhibition by serous of mucinous carcinoma. Inhibition by homologous serous cystadenocarcinoma was observed in two patients. In contrast, squamous cell carcinoma, leiomyosarcoma, and mixed mesodermal tumors of the uterus did not inhibit leukocyte migration from patients with ovarian carcinoma.

#### EXPERIENCES WITH USE OF INTRA- CHOLEDOCHAL HEPARINIZED SALINE FOR TREATMENT OF RETAINED COMMON DUCT STONES

B. Gardner (450 Clarkson Ave., Brooklyn, N.Y. 11203)  
*Ann. Surg.* 177:240-244 (Feb.) 1973

Five patients with retained common duct stones were successfully treated with heparinized saline. The treatment regimen consisted of an intracholedochal drip of 2,500 cc saline containing 25,000 units of heparin given every eight hours continuously around the clock. One week of treatment was successful and no complications were encountered. This treatment of retained common duct stones can be administered with a T-tube in place.

#### GUNSHOT WOUNDS OF ABDOMEN

F. W. Taylor (3524 N. Meridian St., Indianapolis 46208)  
*Ann. Surg.* 177:174-177 (Feb.) 1973.

Seven hundred civilian gunshot wounds of the abdomen were seen over a 40-year period. From 1930 to 1938, mortality was 52.8%. Three successive studies indicate a gratifying decrease in mortality which, from 1962 to 1970, declined to 12.7%. Antibiotics are but one responsible factor. Most important are present electrolyte knowledge and the constant use of gastric suction.

#### NONBACTERIAL PNEUMONITIS WITH MULTIDRUG ANTINEOPLASTIC THERAPY IN BREAST CARCINOMA

F. H. Stutz et al. (J. Blom, Walter Reed General Hosp., Washington, D.C. 20012)

*Can. Med. Assoc. J.* 108:710-718 (March 17) 1973

Seventeen patients with metastatic breast carcinoma were treated with a combination of 5-fluorouracil, methotrexate, vincristine, cyclophosphamide, and prednisone. Six of the patients (35%) developed a syndrome consisting of fever, malaria, dyspnea, hypoxemia, and bilateral pulmonary interstitial infiltrates from 41 to 148 days after institution of therapy. The syndrome varied from a mild to a life-threatening illness with recovery in 10 to 60 days. These cases may represent examples of methotrexate-induced pneumonitis. The high incidence of the syndrome may be related to the concomitant administration of cyclophosphamide with methotrexate.

#### OPERATING ROOM FLASH FIRE FROM USE OF CAUTERY AFTER AEROSOL SPRAY

J. E. Plumlee (Univ. of Kentucky Medical Center, Lexington 40506)

*Anesth. Analg.* 52:202-203 (March-April) 1973

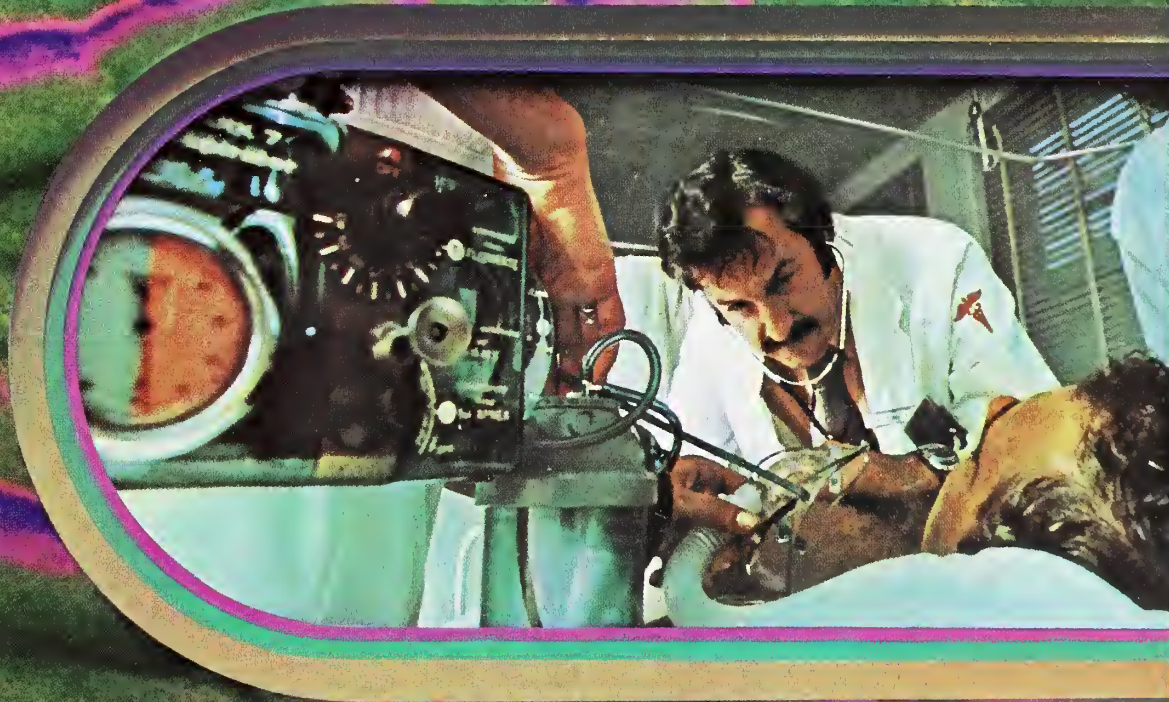
A case is reported in which a flash fire resulted from cauterization of a subcutaneous bleeder following the use of tincture of benzoin aerosol. Tests demonstrated that tincture of benzoin aerosol may be ignited by cautery up to four minutes after application.



On all in-patient  
services...

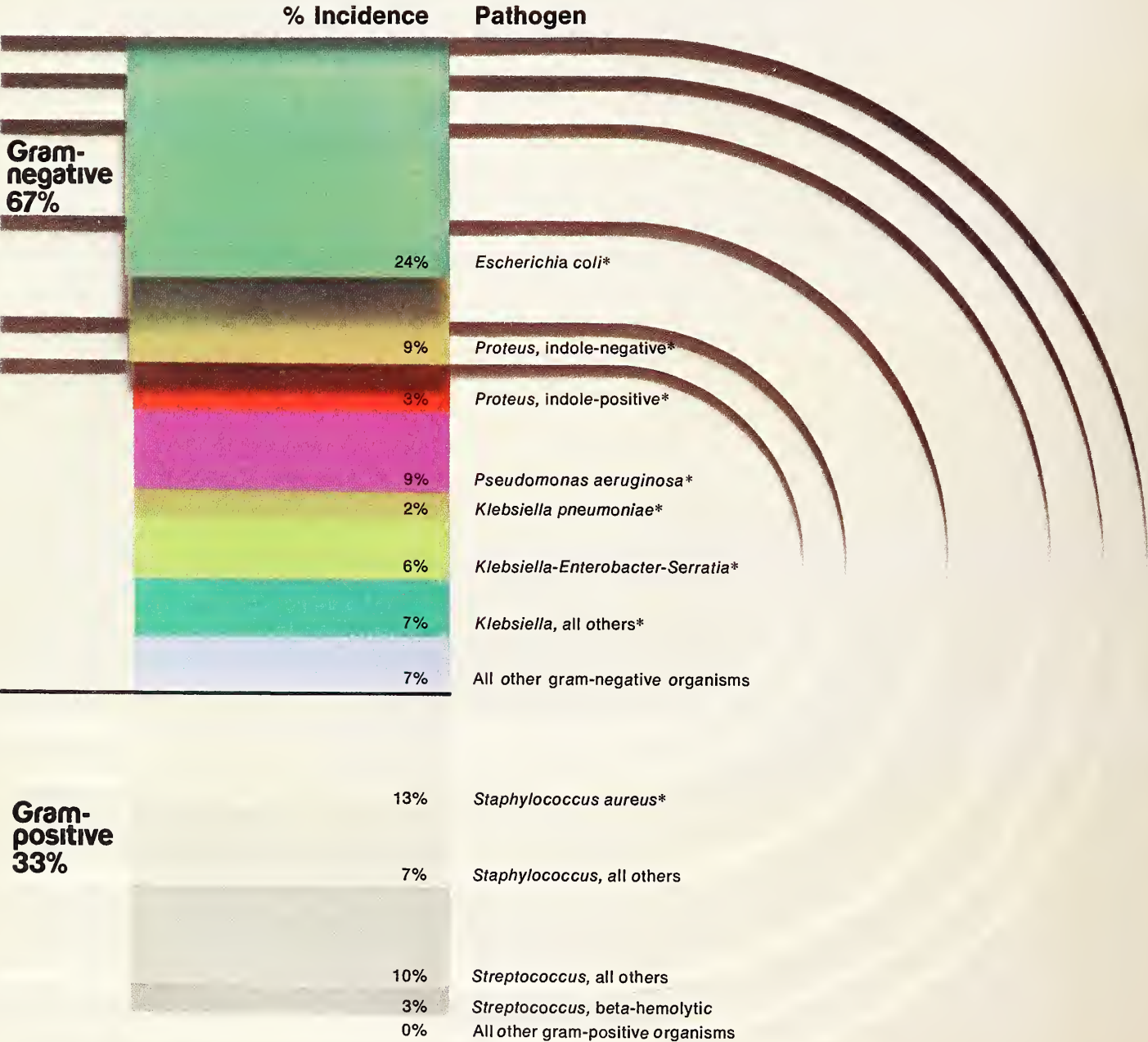
# a major problem

2 out of 3  
nosocomial infections  
are gram-negative





# Commonly encountered pathogens on all hospital services



Total pathogens 21,972  
Source: Gosselin Audit of Pathology Cultures—1971

\*GARAMYCIN Injectable is effective against susceptible strains of the pathogens indicated.



# A highly appropriate spectrum for today's problem pathogens

GARAMYCIN Injectable offers a high probability of effectiveness against susceptible strains of seven out of seven major gram-negative pathogens. These are:

*Escherichia coli*  
*Proteus*, indole-negative  
*Proteus*, indole-positive  
*Pseudomonas aeruginosa*  
*Klebsiella*  
*Enterobacter*  
*Serratia* } species

GARAMYCIN Injectable has also been shown to be effective in serious staphylococcal infections. It may be considered in those infections when penicillins or other less potentially toxic drugs are contraindicated and bacterial susceptibility testing and clinical judgment indicate its use.

## Start with Garamycin

### ■ Broad gram-negative spectrum

Because of its broad gram-negative spectrum and its well-established clinical efficacy, GARAMYCIN Injectable can be considered for initial therapy in suspected as well as documented gram-negative sepsis.

## Stay with Garamycin

### ■ Susceptibility of causative organisms confirmed

The results of susceptibility tests will, in most cases, demonstrate the causative organisms' sensitivity to GARAMYCIN Injectable. However, the decision to continue therapy with this drug should also be based on the severity of the infection and the important additional concepts contained in the Warning Box.

### ■ Relatively low incidence of adverse reactions

Risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

### ■ Bacterial resistance has not been a problem

In the laboratory, resistance has been demonstrated to develop slowly in stepwise fashion. No one-step mutations to high resistance have been reported to date.

On all in-patient services...

**Garamycin<sup>®</sup>**  
**gentamicin**  
**sulfate**  
**Injectable**  
**I.M./I.V.**

**40 mg. per cc.**

Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin

In serious gram-negative infections (pneumonia, urinary tract infections, septicemia, and wound infections)\*

\*Due to susceptible organisms

#### WARNING

Patients treated with GARAMYCIN Injectable should be under close clinical observation because of the potential toxicity associated with the use of this drug.

Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment.

Monitoring of renal and eighth nerve function is recommended during therapy of patients with known impairment of renal function. This testing is also recommended in patients with normal renal function at onset of therapy who develop evidence of nitrogen retention (increasing BUN, NPN, creatinine or oliguria). Evidence of ototoxicity requires dosage adjustments

or discontinuance of the drug.

In event of overdose or toxic reactions, peritoneal dialysis or hemodialysis will aid in removal of gentamicin from the blood.

Serum concentrations should be monitored when feasible and prolonged concentrations above 12 mcg./ml. should be avoided.

Concurrent use of other neurotoxic and/or nephrotoxic drugs, particularly streptomycin, neomycin, kanamycin, cephaloridine, viomycin, polymyxin B, and polymyxin E (colistin), should be avoided.

The concurrent use of gentamicin with potent diuretics should be avoided, since certain diuretics by themselves may cause ototoxicity. In addition, when administered intravenously, diuretics may cause a rise in gentamicin serum level and potentiate neurotoxicity.

**USAGE IN PREGNANCY** Safety for use in pregnancy has not been established.

See Clinical Considerations section which follows...

**On all in-patient services...  
in hospital-acquired gram-negative infections\***

# Garamycin®

## gentamicin sulfate

### injectable

#### I.M./I.V.

**40 mg. per cc.**

Each cc. contains  
gentamicin sulfate equivalent  
to 40 mg. gentamicin

Also available:  
GARAMYCIN® Pediatric Injectable, 10 mg. per cc.

**GARAMYCIN®** Injectable, brand of gentamicin sulfate U.S.P., injection, 40 mg./cc. Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin  
For Parenteral Administration

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**USAGE IN PREGNANCY** Safety for use in pregnancy has not been established.

**INDICATIONS** GARAMYCIN Injectable is indicated, with due regard for relative toxicity of antibiotics, in the treatment of serious infections caused by susceptible strains of the following microorganisms:

**Pseudomonas aeruginosa**, **Proteus** species (indole-positive and indole-negative), **Escherichia coli** and **Klebsiella-Enterobacter-Serratia** species.

Clinical studies have shown GARAMYCIN Injectable to be effective in septicemia and serious infections of the central nervous system (meningitis), urinary tract, respiratory tract, gastrointestinal tract, skin and soft tissue (including burns).

Bacteriologic tests to determine the causative organisms and their susceptibility to gentamicin should be performed.

Bacterial resistance to gentamicin develops slowly in stepwise fashion; there have been no one-step mutations to high resistance.

In suspected or documented gram-negative sepsis, GARAMYCIN may be considered as initial therapy. The decision to continue therapy with this drug should be based on the results of susceptibility tests, the severity of the infection, and the important additional concepts contained in the Warning Box. In the neonate with suspected sepsis or staphylococcal pneumonia, a penicillin type drug is usually indicated as concomitant antimicrobial therapy.

GARAMYCIN Injectable has been shown to be effective in serious staphylococcal infections. It may be considered in those infections when penicillins or other less potentially toxic drugs are contraindicated and bacterial susceptibility testing and clinical judgment indicate its use.

**CONTRAINDICATIONS** A history of hypersensitivity to gentamicin is a contraindication to its use.

**WARNINGS** See Warning Box.

**PRECAUTIONS** Neuromuscular blockade and respiratory paralysis have been reported in the cat receiving high doses (40 mg./kg.) of gentamicin. The possibility of these phenomena occurring in man should be considered if gentamicin is administered to patients receiving neuromuscular blocking agents such as succinylcholine and tubocurarine.

Treatment with gentamicin may result in overgrowth of nonsusceptible organisms. If this occurs, appropriate therapy is indicated.

#### ADVERSE REACTIONS

**Nephrotoxicity:** Adverse renal effects, as demonstrated by rising BUN, NPN, serum creatinine and oliguria, have been reported. They occur more frequently in patients with a history of renal impairment treated with larger than recommended dosage.

**Neurotoxicity:** Adverse effects on both vestibular and auditory branches of the eighth nerve have been reported in patients on high dosage and/or prolonged therapy. Symptoms include dizziness, vertigo, tinnitus, roaring in the ears and hearing loss. Numbness, skin tingling, muscle twitching, and convulsions have also been reported.

**Note:** The risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

Other reported adverse reactions, possibly related to gentamicin, include increased serum transaminase (SGOT, SGPT), increased serum bilirubin, transient hepatomegaly, decreased serum calcium; splenomegaly, anemia, increased and decreased reticulocyte counts, granulocytopenia, thrombocytopenia, purpura; fever, rash, itching, urticaria, generalized burning, joint pain, laryngeal edema; nausea, vomiting, headache, increased salivation, lethargy and decreased appetite, weight loss, pulmonary fibrosis, hypotension and hypertension.

**DOSE AND ADMINISTRATION** GARAMYCIN Injectable may be given intramuscularly or intravenously.

#### For Intramuscular Administration:

##### PATIENTS WITH NORMAL RENAL FUNCTION\*

**Adults:** The recommended dosage for GARAMYCIN Injectable for patients with serious infections and normal renal function is 3 mg./kg./day, administered in three equal doses every 8 hours.

For patients weighing over 60 kg. (132 lb.), the usual dosage is 80 mg. (2 cc.) three times daily. For patients weighing 60 kg. (132 lb.) or less, the

usual dose is 60 mg. (1.5 cc.) three times daily.

In patients with life-threatening infections, dosages up to 5 mg./kg./day may be administered in three or four equal doses. This dosage should be reduced to 3 mg./kg./day as soon as clinically indicated.

\*In children and infants, the newborn, and patients with impaired renal function, dosage must be adjusted in accordance with instructions set forth in the Package Insert.

#### For Intravenous Administration:

The intravenous administration of GARAMYCIN Injectable is recommended in those circumstances when the intramuscular route is not feasible (e.g., patients in shock, with hematologic disorders, with severe burns, or with reduced muscle mass).

For intravenous administration, in adults, a single dose of GARAMYCIN Injectable may be diluted in 100 or 200 cc. of sterile normal saline or in a sterile solution of dextrose 5% in water; in infants and children, the volume of diluent should be less. The concentration of gentamicin in solution, in both instances should normally not exceed 1 mg./cc. (0.1%). The solution is infused over a period of 1 to 2 hours.

The recommended dose for intravenous administration is identical to that recommended for intramuscular use.

GARAMYCIN Injectable should not be physically pre-mixed with other drugs, but should be administered separately in accordance with the recommended route of administration and dosage schedule.

**HOW SUPPLIED** GARAMYCIN Injectable, 40 mg. per cc., 2 cc. multiple-dose vials for parenteral administration.

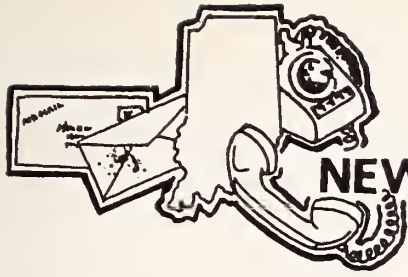
Also available, GARAMYCIN Pediatric Injectable, 10 mg. per cc., 2 cc. multiple-dose vials for parenteral administration.

APRIL, 1972

AHFS Category 8:12.28

**For more complete prescribing details, consult Package Insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.**





## NEWS NOTES

### Use of Physician's Name Demeaning, AMA Judicial Council Reaffirms

The fact that commercial advertisements have appeared recently with the name, photograph and professional appointments of physicians has prompted the AMA Judicial Council to issue warnings that such conduct is unethical. The Council opinion is as follows: "It is demeaning to the medical profession for a physician to permit the use of his name and professional status in the promotion of commercial enterprises. A physician may freely engage in business ventures outside the practice of medicine. However, out of respect for his profession, he should not allow his name or the prestige of his professional status as a physician to be used in the promotion of commercial enterprises."

### Governor Names Dr. Hardigg, Corrections Medical Director

Dr. Jack B. Hardigg, Indianapolis, a member of the Indiana University Medical School faculty, has been named by Governor Otis R. Bowen to the post of medical director for the State Department of Corrections.

He will coordinate medical treatment and study future health needs of inmates in state penal institutions.

### Dr. Zook Serves with Project Hope

Dr. Elvin G. Zook, Indianapolis, chief of plastic surgery at Marion County General Hospital, spent last month as a member of the staff of the hospital ship S.S. HOPE at its present station in northeast Brazil. The ship is at Maceio, 400 miles south of Natal, which was its mission in 1972.

DR. EUGENE RIFNER was honored by his community at an Appreciation Day recently marking the 25th anniversary of his opening an office for the practice of medicine in Van Buren. "This Is Your Life, Dr. Rifner" was the format of the program and featured former patients, employees, relatives and friends who recounted their recollections of their association with Dr. Rifner over the years. Sponsors of the program were the Van Buren Chamber of Commerce, Lions Club, American Legion post, and Central Christian Church. A watch was presented to Dr. Rifner as a token of appreciation. From left to right in the photo are Dr. William Koontz, Dr. Floyd Mohler, Dr. Rifner, Mrs. Martha Wise, Bob Dillon, Mrs. Jean Dillon, Charles Stubbs (hidden), Dr. Virgil Schooler and Fred Poer.



### Dr. Beeler Named Chairman

Dr. John Beeler, Indianapolis, has been selected to serve as chairman of the Commission on Administrative Affairs of the American College of Radiology.

### Hammond Clinic Accredited

The Hammond Clinic of Munster has been accredited by the American Association of Medical Clinics. The accreditation is a voluntary procedure conducted by the Association to testify as to the highest possible quality of patient care and diagnostic scope.

### Dr. James Franco Certified

Dr. James M. Franco, Evansville, was the only candidate from Indiana certified when the American Board of Neurological Surgery recently gave its certifying examination.

### Dr. Akin Not First Female Physician On Evansville State Hospital Staff

*The Journal* was in error when it reported in the May issue that Dr. Emel B. Akin was the first woman to serve on the medical staff at the Evansville State Hospital. At least four other women have also served on the medical staff: Drs. Minerva Pontius, Martha Moore, Margaret Tilden and Isabelle Turner. Our apologies are extended to these and any other women doctors who have served the staff.

### Named Radiology Fellows

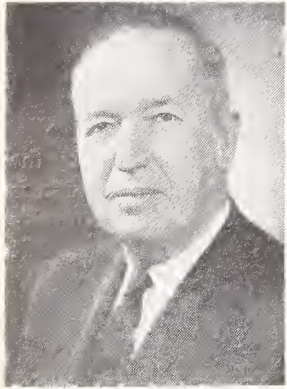
Drs. Wallace E. Childs, Madison, and Eli Blair Harter, Lafayette, have been elected Fellows of the American College of Radiology.

### Self-Help Group Surveyed

Dr. Hanus J. Grosz, Indianapolis, has just completed a survey of "Recovery," a national self-help organization for nervous or former mental patients. The survey concerned 6463 members who attend 500 Recovery groups. It was found that psychiatrists are referring patients to such groups in increasing numbers. "Recovery" utilizes the same principles as Alcoholics Anonymous to provide mutual support and prevent relapse.



## Dr. Kenneth Kohlstaedt Retires, Is Awarded Title of Master by ACP



Dr. Kenneth G. Kohlstaedt, Indianapolis, vice president of medical research for Eli Lilly and Company, retired May 31 after completing a 38-year association with the firm.

In April Dr. Kohlstaedt received the title of Master of the American College of Physicians, an honor previously awarded only one other Hoosier physician.

A graduate of the I.U. School of Medicine, Dr. Kohlstaedt has been a professor of medicine there since 1952. He was certified as a diplomate by the American Board of Internal Medicine in 1945 and is a member of the American Society for Clinical Pharmacology and Therapeutics and a fellow of the American College of Cardiology and the New York Academy of Science. (Photo by Fabian Bachrach)

## Antisubstitution Statement Adopted

Twelve medical, dental and pharmaceutical organizations have adopted a joint statement in support of the traditional prescription drug antisubstitution laws and regulations. The statement, adopted by the national governing bodies of academies and colleges, including the National Association of Retail Druggists, advises against the unauthorized substitution of prescription medicines.

## Dr. Wood Elected ACP Governor

Dr. Donald E. Wood, Indianapolis, was recently elected Governor of the American College of Physicians.

## PMA Creates New Section

The Pharmaceutical Manufacturers Association has created a new Section for Medical Devices and Diagnostic Products. This branch of the industry has increased rapidly both from the manufacturing end and in the field of government control. The major focus of the new Section will be on legislative and regulatory developments.

## Dr. Ziperman Appointed

Dr. H. Haskell Ziperman, graduate of Indiana University School of Medicine, has been appointed Senior Research Physician in the Department of Bioengineering of the Southwest Research Institute. Dr. Ziperman, who had his residency training in surgery at Indiana University, has recently been retired after an outstanding career in the Medical Corps of the U.S. Army.

## Business Advisors Listed

The 1973 roster of the Society of Professional Business Consultants has just been completed and is available to doctors interested in locating a business advisor. Write the Society at 221 N. LaSalle St., Chicago 60601.

## New Educational Film Available

A new educational film, "Bicornuate Uterus, Diagnosis and Management," is now available for showing to medical groups. It is a 27-minute, 16 mm color film produced by E. R. Squibb & Sons. Write to Squibb at P.O. Box 4000, Princeton, N.J. 08540.

## Consultation by Phone Offered

MediPhone, a non-profit physicians' consultation service with headquarters in Chicago, furnishes a person-to-person conversation with a recognized specialist whenever requested by an outlying physician with a baffling medical problem. It operates on a national basis without charge. The cost of MediPhone is defrayed in part by the Pfizer Laboratories and Roerig Divisions of Pfizer Pharmaceuticals as a service to the medical profession. The phone number 312-782-7888.

## Rorer Company Favors Leaving Methaqualone in Schedule III

Methaqualone has, unfortunately, become one of the drugs of abuse. The William H. Rorer Company, which markets methaqualone under their brand name "Quaalude," favors an increased level of control for the drug, but objects to the possibility of having methaqualone placed in Schedule II, which is the schedule which allows medical use with severe restrictions and is reserved for drugs with high abuse potential and severe psychological or physical dependence—such as methadone, raw opium and morphine. Rorer feels that Schedule III is more appropriate. This schedule includes barbiturates and Doriden and other drugs characterized by less abuse potential than Schedule II, with moderate or low physical dependence and high psychological dependence. Physicians who are interested are invited to express their opinion on this matter to the Bureau of Narcotics and Dangerous Drugs, Department of Justice, Room 611, 1405 "I" St. N.W., Washington, D.C. 20537.

## Dr. Black Promoted by Lilly

Dr. Henry R. Black, Indianapolis, has been promoted to director of professional services at the Lilly Laboratory for Clinical Research at the Marion County General Hospital. He has been chief of professional services since 1969.

## Elected to PMA Board

Richard D. Wood, chairman of the Board of Directors, Eli Lilly and Company, has recently been elected to the board of the Pharmaceutical Manufacturers Association.

## Wins Helen Keller Award

James S. Adams, a distinguished alumnus of Indiana University, and now a general partner in the investment banking firm of Lazard Freres & Company, was the recipient recently of the Helen Keller International Award for his efforts in promoting medical research to prevent blindness. The Keller Award is presented periodically by the American Foundation for Overseas Blind for meritorious service in either work for the blind or for prevention of blindness.

Continued



## NEWS NOTES

Continued

### Color Film on TIA Available

Marion Laboratories has a continuing education color film for physician groups. The title is "T.I.A.s—An Early Warning System of Impending Stroke." It deals with the early recognition and diagnosis of the stroke-prone individual who has transient ischemic attacks (T.I.A.s). It is a 16 mm color film and runs 31 minutes. Phone or write Mr. James A. Byrnes, 816-761-2500, Marion Laboratories, 10236 Bunker Ridge Road, Kansas City, Mo. 64137.

### Winona Staff Elects Olvey

**Dr. Ottis N. Olvey**, Indianapolis, has been elected president of the Winona Hospital medical staff. Others who took office recently are **Dr. Ramon S. Dunkin**, vice president, and **Dr. George H. Rawls**, secretary-treasurer.

### Hartford Foundation Grant Made

The Hartford Foundation announces that it has appropriated \$65,777 to augment a sum of \$56,847 which was awarded last year to Indiana University School of Medicine for research on axoplasmic flow: The transport of materials in nerve fibers.

### Kiwanians Honor Dr. Wiseman

**Dr. Earle Wiseman**, Greencastle, retired surgeon, was honored recently by the Greencastle Kiwanis Club when he was named Distinguished Senior Citizen of Putnam County. Dr. Wiseman is a Senior Member of ISMA.

### Disaster Preparedness Film, Literature Available Free

"Date With Disaster" is a new 16-mm Kodachrome training film which documents the multi-hospital preparedness model of the Hospital Council of Southern California. The film is narrated by Jack Webb. Running time is 30 minutes. It is available on a free loan basis for use by communities as an aid in developing medical preparedness plans for natural disasters. Write William Gallagher, Film Distribution Branch, General Services Administration, Washington, D.C. 20409 or call him on Area Code 301/763-7786.

### Dr. E. B. Harter Appointed

**Dr. E. Blair Harter**, Lafayette, has been appointed by Governor Otis Bowen to a four-year term on the advisory committee for the Indiana State Soldiers Home.

**ACUPUNCTURE ANESTHESIA**—An Associated Press story on April 24 reported that a Gary woman who had a tooth pulled while receiving an acupuncture treatment said she felt no pain whatsoever. She said she felt only some pressure during the extraction.

About 40 dentists watched the demonstration of the Chinese medical technique by **Wei-Ping Loh**, M.D., a Gary pathologist who is a native of China.

Dr. Loh used eight one-half inch and two inch needles, inserted in the woman's face, hands and knees. The demonstration was given during a meeting of the Northwest Indiana Chapter of the Academy of General Dentistry.

The needles were connected by wire to an "electric box" which sent 9 volts of electricity from a battery, and Dr. Loh also twisted the needles manually during the treatment.

### Dr. Thomas Attends Congress

**Dr. Daniel D. Thomas**, Gary, recently returned from the Orient where he attended the 25th Annual Congress and Teaching Seminar of the International Academy of Proctology. He is president-elect and will be installed as president of the Academy in May 1974 in Montreaux, Switzerland.

### Dr. Ralph Butz Elected President Of Physicians and Surgeons Group

**Dr. Ralph O. Butz**, Muncie, surgeon, was recently elected president of the Indiana Chapter of Association of American Physicians and Surgeons. Others elected were **Dr. Forrest Babb**, Stockwell, vice president, and **Dr. Helen B. Barnes**, Greenwood, secretary.

Named to the executive committee were **Drs. Frank Albertson**, Indianapolis, Helen Calvin, South Bend, **Edwin McDaniel**, Indianapolis, **Thomas Neathamer**, Jeffersonville, and **William Sholty**, Lafayette.

**Drs. Babb**, **Hugh Ramsey**, Bloomington, **Paul Burns**, Montpelier, **John MacLeod**, South Bend, and **David Sluss**, Indianapolis, were chosen as delegates to the national meeting.

### Family Practice Exam Dates Set

The American Board of Family Practice announces that it will give its next two-day written certification examination on October 20-21, 1973. It will be held in various centers geographically distributed throughout the United States. Information regarding the examination can be obtained by writing:

Nicholas J. Piscano, M.D., Secretary  
American Board of Family Practice, Inc.  
University of Kentucky Medical Center  
Annex #2, Room 229  
Lexington, Ky. 40506

It is necessary for each physician desiring to take the examination to file a completed application with the Board office. Deadline for receipt of applications in the ABFP office is *August 1, 1973*.



# For an organization supposedly opposed to change, the AMA has made a lot of changes.

One of the most significant was the addition of an important new voice in the AMA—that of interns and residents. For the first time, these young physicians have not only a voice but also a vote in helping shape AMA policies.

Recently, the AMA House provided the same opportunities for membership and participation to medical students.

That's not all. In another important change, the AMA's council-committee structure has been streamlined. Some councils and committees have been dropped. Others have been made more efficient by reducing their size to seven members for councils and five for committees. And to permit more frequent infusion of new

members and ideas, maximum tenure of service has been reduced to seven and five years, respectively.

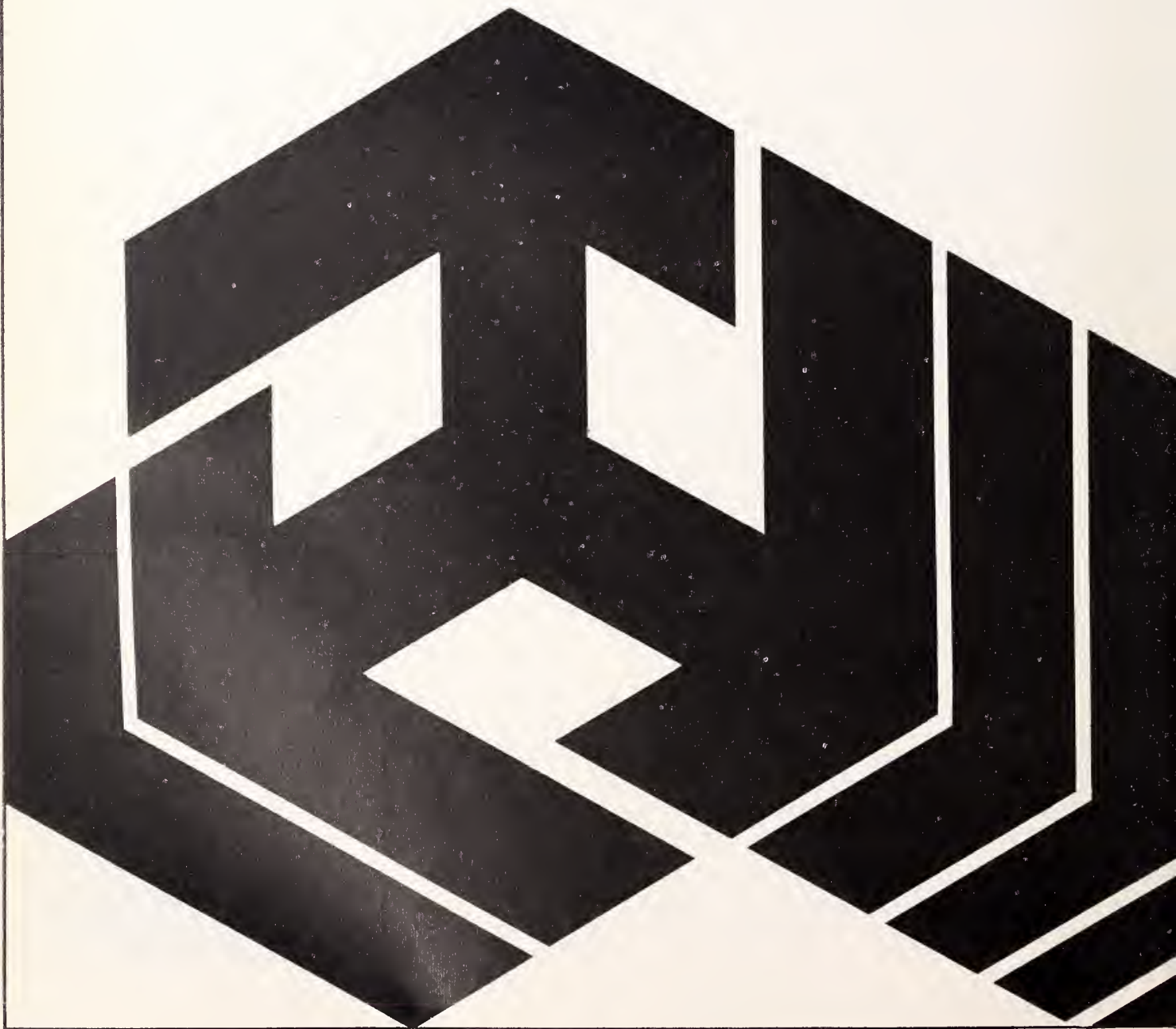
The AMA *has* made a lot of changes. Changes to make it more responsive to the ideas of *all* physicians...changes to make it more effectively serve the needs of the profession.

Change will continue. But it will be decided only by those of you interested and dedicated enough to be a force in that change.

**Join us.**

**We can do much more together.**

American Medical Association  
535 N. Dearborn St./Chicago, Ill. 60610





## FUTURE MEETINGS, SEMINARS, COURSES

### Pediatrics Course Offered

The Sixteenth Postgraduate Course in Pediatrics will be conducted by the University of Colorado School of Medicine from July 29 to August 1, inclusive. The tuition is \$100. Write to Office of Postgraduate Medical Education, 4200 E. Ninth Ave., Denver 80220.

### Announce Sports Injuries Program

A program on athletic injuries has been scheduled for Aug. 15 from 1:00 to 9:00 p.m. at the Notre Dame University Athletic and Convocation Center. Coaches, trainers, athletic directors and principals, as well as physicians interested in the problems of sports injuries, may attend. Accepted by the American Academy of Family Practice under their requirements for continuing education. Advance reservation requested; no registration fee; dinner \$4.00. Write Leslie M. Bodner, M.D., Albert Dingley, M.D., Co-Chairmen, St. Joseph County Committee on Sports Injuries, 328 N. Michigan, South Bend 46601.

### More-Effective-Speaker Programs Announced for Three Fall Dates

The AMA Speakers and Leadership Programs to be given this fall have been announced for the weekends of Aug. 31-Sept. 2, Oct. 26-28 and Nov. 16-18. Sessions include theory and drills on message preparation, delivery, fielding of questions, as well as individual coaching and instant TV playback. Programs are

held at the Marriott Motor Hotel, O'Hare Airport, Chicago. For further information write or call Mortimer Enright, director, AMA Speakers and Leadership Programs, 535 N. Dearborn St., Chicago, Ill. 60610; (312) 751-6484.

### Emergency Medicine, Nursing Course Scheduled at Dallas

Postgraduate courses for emergency physicians and emergency nurses will be conducted on the general subject of "Practice of Emergency Medicine" at the Dallas Convention Center on October 23, 24 and 25. The meeting is sponsored by the American College of Emergency Physicians and the Emergency Department Nurses Association. For ACEP/EDNA members registration prior to September 15 is \$55, later \$60. For non-members it is \$85/\$90. Address ACEP/EDNA Scientific Assembly, Dallas Housing Service, Chamber of Commerce, 1507 Pacific, Dallas, Texas 75201.

## NOW IN OUR 112th YEAR OF RESTORING CONFIDENCE TO THE DISABLED

The year 1973 marks one hundred and twelve years of service in the field of prosthetics for the Hanger Organization. Over the years the name Hanger has become synonymous with fine prosthetic appliances.

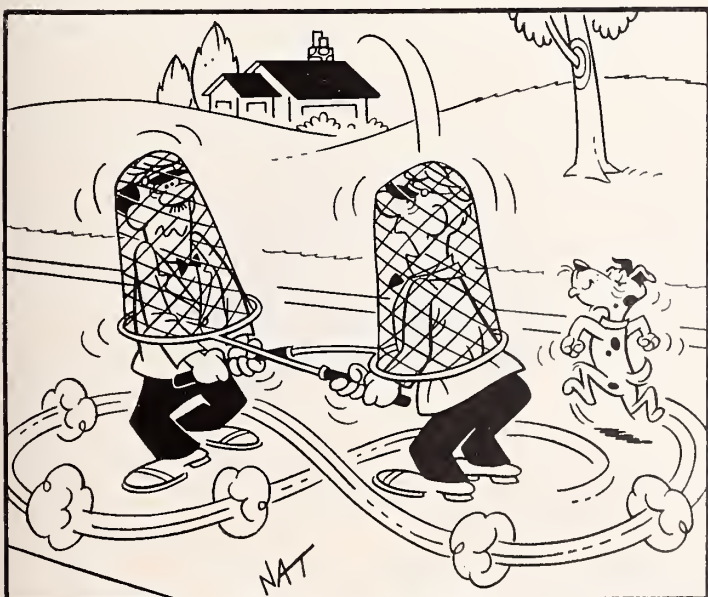
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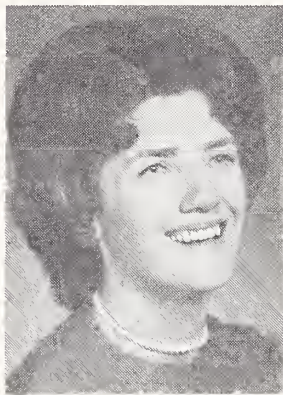


"YOU WEREN'T KIDDING! HE IS TRICKY!"

# *The Woman's Auxiliary* REPORTS TO ISMA

Sometimes we feel as if we just couldn't handle one more thing, no matter how deserving and good the cause—and I couldn't agree more. But at this point in time something keeps hammering at our conscience and the Woman's Auxiliary to the AMA is taking on another project this year—that of seeing what can be done about the abused, neglected and battered child. Of course, this is not unique with Auxiliary nor did it just begin this year even in our group. Several county auxiliaries around the country are already involved and so are many other community health agencies. As this terrible problem relates to Indiana, I would hope that those efforts now being made to do something about it can continue and be further reinforced by the medical profession and their wives.

The AMA policy states that it is their belief that vigorous and effective action must be taken to protect the abused child. Many adults who beat their children were themselves beaten as children. People who do this beating represent a cross section of society. It is not the problem of just one group.



I was privileged to attend an all-day conference in Fort Wayne this spring presented by the Office of Continuing Education and Special Programs, Indiana University, Fort Wayne, and sponsored by several groups, including the Fort Wayne Medical Society and the Allen County Bar Association. The main speaker was Mark Hildebrand, M.D., associate professor of pediatric medicine, University of Michigan, and team chairman of SCAN (Suspected Child Abuse and Neglect). His topic was "The Therapeutic Approach to Child Abuse Problems." This syndrome of the battered child is so repugnant to us that our first reaction is one of rage, to "get the abuser," protect that child from its parent, get it into a place where it won't be hurt anymore. The sad truth is, however, that really this won't usually help that child. Yes, after a report is made, the police investigate, take the child away probably, but very often that child is back in that home in a matter of hours or days. Unless something can be done to rehabilitate that parent and change the environment which brought on the abuse, we really haven't helped the child.

Every state has a reporting law and Indiana is no exception. We need to be familiar with these laws as they apply to our communities. We need also to see what help is available in the community to help the child and his parents to prevent abuse, treat both parent and child when it occurs and, above all, to prevent recurrence of the abuse. Solutions must focus on adjusting the environment to protect the child from willful physical injury. We need to develop public understanding of the problems and a willingness to support the measures necessary for its elimination.

Beyond the abused child, his parents, and his family, is the community. Battering parents and their families suffer community exclusion, whether economically, politically, psychologically or socially. Unfortunately, when such persons vent their rage on their children and a shocked community retaliates, the family's sense of rejection increases. A cycle of reciprocal aggression is set in motion that is hard to stop. Somewhere, somehow, we must give these parents an opportunity to learn how to become adequate parents. At least 80% of them **can** be rehabilitated.

There are so many steps to be taken that it would be impossible to make a list. I have just mentioned the problem to report to you that the Auxiliary is aware and cares about the social problems in our communities. We will, with your approval, do whatever we can to help educate and coordinate efforts of various community agencies. If your medical society is interested in setting up or participating in a conference of this kind, I'm sure the group that did it in Fort Wayne would be glad to share their hopes and plans. It also goes without saying that the Woman's Auxiliary will too.

*Pat Stogsdill*

President, Woman's Auxiliary  
Indiana State Medical Association



## From The Journal 50 Years Ago

It has been said, and very truly I believe, that "The weakest link in the chain of clinical medicine is the application of correct treatment." Within my own recollection the therapeutic pendulum has swung repeatedly from absolute nihilism to unreasonable polypharmacy. The only interpretation of this is lack of confidence in, or lack of knowledge of, the action of drugs. Certainly every intelligent physician believes in the efficacy of well-directed medication, and one should acquaint himself thoroughly with the action of a few useful drugs and then use them when they are indicated.

Of such potent drugs there is perhaps no one of greater clinical value than digitalis. Used intelligently it promotes well-being, increases comfort, and oftentimes actually saves life. But its intelligent use is practically restricted to just a single pathological entity, and that is cardiac decompensation. . . . Pomeroy and Heyl found that most infusions were worthless at the end of from three to five days; and even if freshly prepared, their potency depends upon the skill of the pharmacist and the activity of the leaves from which they are made.

Tinctures prepared by reliable pharmaceutical laboratories are dependable, but here again much depends upon the freshness of the preparation, for tinctures, too, are apt to deteriorate rapidly. . . . Another practical and very serious objection to the use of tincture is the variation in dose which comes from the common practice of confusing minim with drop. Fifteen minims equal a cubic centimeter, but the number of drops which equal a cubic centimeter varies with the dropper. I have recently tested a number of ordinary medicine droppers and found a variation of from 25 to 45 drops to the cubic centimeter, while experiments at the Peter Bent Brigham Hospital made some time ago showed a variation of from 30 to 56 drops. It is obvious then that most patients taking tincture of digitalis are receiving considerably less of the drug than the physician really prescribed, and this no doubt accounts for many digitalis failures.

Thomas J. O'Brien, in a most practical article which appeared recently in the **Boston Medical and Surgical Journal**, says: "The whole leaf possesses all the valuable properties of digitalis and is the best way of giving this important drug." I heartily concur in this opinion. I have found it to be dependable and the results uniformly satisfactory. It is of prime importance that the drug be reasonably fresh and that it be prepared from leaves whose potency is assured. To secure these attributes it is necessary that the powdered leaf be secured from a pharmaceutical house whose label is an assurance of quality. It is best administered in the form of a pill or a capsule made from the powdered leaf, and as a matter of convenience prepared in doses of three-fourths of one grain, and one and one-half grains. I believe it best that this particular drug be dispensed by the physician himself and that it be given under his personal direction and observation. . . . — Edgar F. Kiser, M.D., Indianapolis, "Digitalis Therapy," JISMA, July 1923.



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# County, District News

## Eighth District

Meeting date has been changed to August 29, Green Hills Country Club, Muncie.

## Tenth District

Meeting date has been changed to September 5, Lakes of the Four Seasons Country Club, Valparaiso.

## Eleventh District

Meeting date has been changed from September 19 to October 3, Meshingomesia Country Club and Emley's Restaurant, Marion.

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A number of county and district societies have elected officers, as follows:

## First District

President, Dr. William Dye, Oakland City; vice president, Dr. Albert Ritz; secretary, Dr. John Bender, both of Evansville. Dr. Bernard B. Rosenblatt, Evansville, was named trustee, and Dr. Ralph Carlson, Evansville, Blue Shield Board member.

## Second District

Dr. J. S. Brown, Carlisle, was elected to his 52nd consecutive term as secretary of the second District. The Sullivan County Society will select the District President.

## Fourth District

President, Dr. Joe M. Black, Seymour; vice president, Dr. William J. Warn, Milan; secretary-treasurer, Dr. John W. Ripley, Seymour; alternate trustee, Dr. William Blaisdell.

## Fifth District

President, Dr. J. Franklin Swain, Rockville; secretary, Dr. Antolin M. Montecillo, Clinton; alternate trustee, Dr. William G. Bannon; Blue Shield Board member, Dr. Fred W. Dierdorf, Terre Haute.

## Sixth District

President, Dr. James H. Tower, Jr., Shelbyville; vice president, Dr. Davis W. Ellis, Jr., Rushville; secretary, Dr. Arlington M. Hudson, Connersville; trustee, Paul M. Inlow, Shelbyville.

## Allen

President, Dr. Richard B. Juergens; president-elect, Dr. Robert J. Schmoll; secretary, Dr. Herbert K. J. Acker; treasurer, Dr. Peter A. Blichert, chairman of board, Dr. Kenneth F. Isenogle.

Drs. W. R. Cast, F. W. Dahling, J. S. Farquhar, D. L. Hull, J. J. Mastrangelo and M. E. Priddy will serve as delegates with Drs. W. C. Ashman, T. A. Felger, C. S. Giffin, T. L. Herendeen, J. M. Hoog and H. D. Tunnell as alternate delegates.

## Clark

President, Dr. Thomas J. Corrao; vice president, Dr. George H. Rudwell; secretary-treasurer, Thomas A. Neathamer, all of Jeffersonville.

## Dearborn-Ohio

President, Dr. George G. Morrison, Jr., Lawrenceburg; vice president, Dr. Ivan Lindgren, Aurora; secretary, Dr. Leslie M. Baker, Aurora.

## Dubois

President, Dr. Alfred B. Scales, Huntingburg; secretary, Dr. Daniel C. Drew, Jasper.

## Kosciusko

President, Thomas F. Keough; secretary, Roland Snider, both of Warsaw.

## Owen-Monroe

President, Dr. H. Richard Schell; secretary, Dr. Larry D. Ratts, both of Bloomington.

## St. Joseph

President, Dr. Robert Dodd; president-elect, Dr. Gordon Cook; secretary-treasurer, Dr. Robert Nelson; assistant secretary-treasurer, Dr. David Spalding, all of South Bend.

## Vanderburgh

President, Dr. L. Ray Stewart; president-elect, Dr. C. Curtis Young; vice president, Dr. R. W. Nicholson, Jr.; treasurer, Dr. Jerry D. Becker. Drs. Ray H. Burnikel and B. B. Rosenblatt were chosen as delegates, with Drs. Charles W. Hachmeister and Donald C. Buehner alternate delegates.

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## Clinical Pharmacology Training Programs Described

Pfizer Pharmaceuticals has just published a 105-page booklet, "Clinical Pharmacology—A Guide to Training Programs." It describes the 50 programs offered in the U.S. and Canada and outlines application procedures. The demand for specialists in clinical pharmacology greatly exceeds the supply. Many more clinical pharmacologists are needed to help discover and evaluate new drugs. Copies of the booklet will be made available to medical schools. A limited number of copies are available to physicians by writing Pfizer Public Affairs Division, 235 E. 42nd St., New York City 10017.



# Deaths

## Harry A. Bishop, M.D.

Dr. Harry A. Bishop, 61, who had practiced medicine at Frankton since 1947, died at his home April 11.

A native of Iowa, he was a graduate of the University of Louisville Medical School and interned at St. Joseph's Infirmary, Louisville. During World War II he served with the Army Medical Corps. He was active in relief of victims of the Ohio River flood disaster in the Louisville area in 1937.

A member of the AMA and the Madison County Medical Society, he was on the staff of Mercy Hospital, Elwood, and Community and St. John's hospitals, Anderson.

## Charles L. Botkin, M.D.

Dr. Charles L. Botkin, 94, retired Muncie physician, died April 19 at a nursing home.

Following graduation from the Indiana Medical College of Indianapolis, he practiced medicine in Farmland from 1904 to 1924. In 1924 he moved to Muncie and continued practice there until 1939, when he retired.

A Senior Member of the Delaware-Blackford County Medical Society, he was also a member of the AMA and the American Society of Dermatologists.

## Norman R. Booher, M.D.

Dr. Norman R. Booher, 65, Indianapolis died April 29.

A graduate of the Indiana University School of Medicine in 1934, Dr. Booher served his internship at the Indianapolis City Hospital and from 1936 to 1940 was chief deputy coroner for Marion County. He was an Army medical officer during World War II and served on the staff of General Dwight D. Eisenhower at Rheims, attaining the rank of colonel.

He was a former vice chairman of the AMA Commission on Voluntary Health Agencies and served as chairman of the ISMA Commission on Voluntary Health Agencies for 18 years. Active in the Marion County Medical Society and the American Academy of Family Practice, Dr. Booher was also a member of the Marion County and Indiana Boards of Public Welfare and had served as

state president for two years. He was former vice chairman of the National American Legion Rehabilitation Commission.

## George Dillinger, M.D.

Dr. George Dillinger, a former French Lick physician who had been on the staff of a Veterans Hospital at Thomasville, Ga., for many years, died in mid-April. He retired four years ago due to ill health.

Dr. Dillinger served as secretary of the Orange County Medical Society from 1931 to 1942 and was an AMA delegate from 1939 to 1945, having served as alternate delegate from 1936 to 1938. Other ISMA service included chairmanship of the Convention Arrangements Committee in 1933, 1937, 1940 and 1942, membership on the Committee on Legislation and Public Policy and chairmanship of the Section on Medicine in 1938.

## Robert W. Gehres, M.D.

Dr. Robert W. Gehres, Shelbyville, died May 30 at Major Hospital. He was 75 and had retired in 1972 after practicing in Shelbyville since 1926.

A 1925 graduate of the Indiana University Medical School, Dr. Gehres served as a Navy medical officer in World War II, retiring with the rank of Commander. He also served as an Army sergeant in World War I.

Dr. Gehres was a Senior Member of the Shelby County Medical Society, which he served as president in 1960.

## Robert E. Holsinger, M.D.

Dr. Robert E. Holsinger, 67, died in Clearwater, Fla., May 15. From 1928 to 1972 he was in practice as a dermatologist in Fort Wayne.

A 1936 graduate of the Indiana University School of Medicine, Dr. Holsinger interned at St. Joseph's Hospital, Fort Wayne, and was a resident at Indianapolis General Hospital from 1951 to 1954. In 1957 he was certified by the American Board of Dermatology. During World War II he served with the Army Medical Corps.

He was a member of the Allen County Medical Society and the AMA.

## William H. Hutto, M.D.

Dr. William H. Hutto, 61, died May 14 at Little Traverse Hospital, Petoskey, Mich.

Dr. Hutto, who was in general practice, was a member of the Howard County Medical Society for a number of years before moving to Michigan to practice.

A 1937 graduate of the Indiana University School of Medicine, he practiced in Kokomo and served as secretary of the county society in 1939.

## James Gordon Kidd, M.D.

Dr. James Gordon Kidd, 83, who practiced medicine in Roann until 1956, died at the Fort Wayne Veterans Hospital April 3.

From 1956 to 1962, when he retired, Dr. Kidd was on the staff of the Wood Veterans Hospital near Milwaukee.

He was a graduate of the Indiana University School of Medicine and was a Senior Member of the Wabash County Medical Society and the American Medical Association. He also belonged to the ISMA Fifty-Year Club. He was a veteran of World War I.

## Glynn Adams Rivers, M.D.

Dr. Glynn A. Rivers, 57, Muncie, died at his home April 27. He retired from active practice in January because of ill health.

A graduate of the Indiana University School of Medicine, he was a former president of the Indiana University Alumni Association. After an internship at Indianapolis General Hospital Dr. Rivers was employed in the Surgeon General's office in Washington in 1941-1942. He served in the Navy in World War II and opened his practice in Muncie in 1946. He also served during the Korean conflict.

He was past president of the Delaware-Blackford Medical Society, past chairman of the clinical staff at Ball Memorial Hospital, past chairman of the hospital's executive committee, served as a delegate to the ISMA Convention for nine years and was on the Constitution and Bylaws Committee in 1963. He was also a member of the AMA. ◀

# Association News

## EXECUTIVE COMMITTEE

Saturday, April 14, 1973

The Executive Committee was called to order at 2:00 p.m., by Doctor Kerr, the chairman. Roll call showed the following present: Donald M. Kerr, M.D., Vincent J. Santare, M.D., James H. Gosman, M.D., Joe Dukes, M.D., Gilbert M. Wilhelmus, M.D., Hugh K. Thatcher, Jr., M.D., Arvine G. Popplewell, M.D., Frank B. Ramsey, M.D., and Jas. A. Waggener.

MINUTES OF THE MEETING held February 17 were approved on motion by Doctor Thatcher and a second by Doctor Wilhelmus.

THE MEMBERSHIP REPORT was reviewed and the suggestion was made that future membership reports two columns are to be carried so a ready comparison can be made of membership classifications.

	ISMA	AMA
Members as of December 31, 1972	4,591	4,246
Paid state dues but not AMA dues as of 12/31/72		341
	ISMA	AMA
Membership Report as of March 31, 1973		
Full dues members	3,620	3,359
Interns and Residents	47	34
Exempt	482	482
Totals	4,149	3,875
Paid state dues but not AMA dues as of 3/31/73		274

### HEADQUARTERS OFFICE

REPAIRS OF BUILDING — The secretary reported that he had the water leak fixed in the wall and the roof repaired over the entrance way.

WATER SEEPAGE ON EAST SIDE OF BUILDING — The secretary reported that, in order to solve this problem, the cement stoop at the east door would have to be torn out and excavation would be necessary along the wall area to put a coating on the blocks to stop this seepage. He further stated he expected to have an estimate of the cost at the time of the meeting but it was not received. The secretary was instructed to proceed with the repair.

TEL-MED REPORT — The secretary reported in the four weeks' operation of Tel-Med we had had 10,196 calls, with April 12 being the heaviest day with 787 calls on that one day. He further reported he was getting letters and commentary on extending the hours of Tel-Med operation until at least 8:00 p.m. on week days and on Saturdays, in order

that working people might have an opportunity to use this service. By consent, this was referred to the Board of Trustees.

MEMBERSHIP POLICY ON PUBLIC HEALTH PHYSICIANS — The secretary requested a policy on membership classification of physicians in the Public Health Service. Upon motion of Doctor Dukes and a second by Doctor Wilhelmus, this is to be referred to the Board of Trustees.

JOINT MEETING OF INDIANA HOSPITAL ASSOCIATION and ISMA — A request of the Indiana Hospital Association for a joint meeting of the two executive committees on May 23 was reviewed and, upon motion of Doctor Wilhelmus and a second by Doctor Santare, it was moved to hold such a meeting but it was suggested to have the meeting Saturday, May 19, 1973.

### TREASURER'S REPORT

THE TREASURER REVIEWED in detail the report of the financial transactions of the Association. The report was approved upon motion of Doctor Thatcher and a second by Doctor Wilhelmus.

### ORGANIZATIONAL MATTERS

MULTIPHASIC HEALTH SCREENING — The secretary informed the committee of the activities of two organizations—American Health Profiles, Inc., of Nashville, Tennessee and United Health Systems, Inc., of Northbrook, Illinois, which were coming into Indiana making contact with labor unions to do a complete physical screening of union membership. The secretary then read a letter from the State Board of Medical Registration and Examination and the Indiana State Board of Health concerning the legality of this operation and also distributed policies of multiphasic screening as adopted by the Ohio State Medical Association and the Jefferson County Medical Society of Louisville. Upon motion of Doctor Santare and a second by Doctor Gosman, these matters were referred to the Board of Trustees with the recommendation that a special committee be established to study this matter.

RENEWAL OF MEMBERSHIP IN U. S. CHAMBER OF COMMERCE — Amount of \$50.00 was appropriated upon motion of Doctor Thatcher and a second by Doctor Gosman.

ADVISORY LETTER REGARDING REVOCATION HEARINGS — A letter to the Board of Medical Registration and Examination from a Deputy At-

torney General concerning the right of the Medical Board to suspend a physician's license by revocation for a given period of time was read and, by consent, this is to be referred to the Medical Disciplinary Committee of the Board of Trustees.

REQUEST FOR USE OF MAILING LIST — A request from the Howard Clinic, Inc., of Logansport for use of the mailing list was approved upon motion of Doctor Gosman and a second by Doctor Wilhelmus.

A request of the Fort Wayne Children's and Maternity Homes for use of the mailing list was approved upon motion of Doctor Wilhelmus and a second by Doctor Thatcher.

REQUEST FROM GEORGIA STATE UNIVERSITY FOR USE OF MAILING LIST — The request was denied upon motion of Doctor Gosman and a second by Doctor Santare, inasmuch as such a study has already been completed by Dr. Raymond Murray, Chairman, Department of Community Health Sciences, Indiana University School of Medicine.

PERMISSION TO FILE AMICUS CURIAE BRIEF — Letter from the Association's attorney informing the Association that the court had agreed to the Association entering into a lawsuit against a physician in Lake County as amicus curiae.

LETTER FROM THE ATTORNEY FOR THE INDIANA ASSOCIATION OF OSTEOPATHIC PHYSICIANS expressing an interest in cooperating with the medical profession in establishing a PSRO program was read for the information of the committee.

WORKMEN'S COMPENSATION ACT AS APPLIED TO M.D.S — A letter from the attorney concerning a physician's responsibility under the Workmen's Compensation Act was read and, by consent, referred to the Board of Trustees and also ordered to be included in the News Flash.

REGION XI QUESTIONNAIRE — A questionnaire being distributed by Region XI of the Comprehensive Health Planning Council was reviewed and, by consent referred to Doctor Popplewell's Committee on Comprehensive Health Care.

A LETTER FROM THE INDIANA ACADEMY OF SCIENCE inviting the Association to submit nominations for membership on the Indiana Council on Science and Technology was reviewed and, by consent, the names of Drs. Kenneth G. Kohlstaedt, Lester H. Hoyt and Kenneth R. Woolling are to be submitted.



LETTER FROM THE NATIONAL CENTER FOR VOLUNTARY ACTION OF WASHINGTON, D.C., seeking approval of the Association for this group to work with the Woman's Auxiliary in attempting to increase the number of people immunized against rubella was approved upon motion of Doctor Wilhelmus and a second by Doctor Gosman.

LETTER FROM THE INDIANA HOSPITAL ASSOCIATION addressed to the State Department of Public Welfare was read and, upon motion of Doctor Gosman and a second by Doctor Wilhelmus, this is to be referred to the Commission on Governmental Medical Services for possible follow through.

LETTER FROM F. J. BABB, M.D., Stockwell, was read for the information of the committee.

AN ITEM APPEARING IN THE ALABAMA M.D. which stated that Alabama law requires that a physician threatened or sued for professional liability be reported to their Board of Medical Registration. By consent, this item is to be referred to the Board of Trustees.

LETTER FROM THE INDIANA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS transmitting a memorandum from the American Academy of Pediatrics in which they sought approval for a letter to be addressed to the pediatricians in Indiana over the signature of the President of the Indiana State Medical Association was approved upon motion of Doctor Gosman and was taken by consent.

LETTER FROM AMA CONCERNING VACANCIES COMING UP AS OF DECEMBER 31, 1973, was reviewed and, upon motion of Doctor Gosman and a second by Doctor Wilhelmus, Dr. John Farquhar and Dr. Sprague Gardiner are to be contacted to see if they have recommendations for nominees to fill their vacancies and also to contact the Chairmen of Section groups involved for any recommendation they might have. This matter was also referred to the Board of Trustees for any suggestions they might have.

A RESOLUTION FOR PRESENTATION TO THE AMA HOUSE OF DELEGATES CONCERNING A CLASS ACTION SUIT submitted by Doctor Harshman was referred to the Board of Trustees upon motion of Doctor Thatcher and a second by Doctor Gosman.

A RESOLUTION ON SPECIAL AC-

TIVITIES PREPARED BY COMMISSION FOR SUBMISSION TO THE AMA HOUSE OF DELEGATES dealing with increasing the number of available residencies in Family Practice was referred to the Board of Trustees upon motion of Doctor Gosman and a second by Doctor Thatcher.

A LETTER FROM AMA CONCERNING ACTION OF AMA HOUSE OF DELEGATES URGING STATE AND COUNTY SOCIETIES TO establish committees for the purpose of handling problems of the sick physician was reviewed and, upon motion of Doctor Gosman and Doctor Santare, this matter was referred to the Board of Trustees.

AMA-ERF GRANT CHECK — The secretary announced that he has received from AMA-ERF a check in the amount of \$21,534.45 and some problems he was having in getting the check back into the hands of the Indiana Medical Education Foundation was discussed and, by consent, Doctor Gosman is to discuss this with the dean of Indiana University School of Medicine.

AN ITEM IN THE GREEN SHEET concerning the Pennsylvania Medical Society financing an intern-resident delegate to the AMA Intern and Resident Business Session of the AMA meeting in New York was reviewed for the information of the committee.

ANNOUNCEMENT FROM THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA announcing they were nominating Dr. Raymond T. Holden for the position of president-elect of the AMA was reviewed for the information of the committee.

#### **BLUE CROSS-BLUE SHIELD MATTERS**

A COMPLAINT OF A FORT WAYNE PHYSICIAN concerning the action of Blue Cross-Blue Shield, requesting certain fiscal information on their plan, was reviewed and it was suggested that the complaint be referred to their Blue Shield Board members representing that district.

A LETTER FROM AN INDIANA PHYSICIAN concerning a complaint against Blue Shield's payment policies was reviewed and taken as a matter of information.

#### **JOURNAL**

A REPORT OF THE PRESIDENT OF THE STATE MEDICAL JOURNAL ADVERTISING BUREAU, INC., pointing out the operating expenses for journals for the year 1972 were 13.96%, a re-

duction of about 2% over the operating expenses for 1971, and pointing out the fact that the INDIANA JOURNAL ranked 27th out of 43 journals in total pages of advertising carried in 1972. This was taken as a matter of information.

#### **MEDICAL DEFENSE**

A STATEMENT FROM A PHYSICIAN MEMBER FOR REIMBURSEMENT TO AN ATTORNEY OF HIS CHOICE in a professional liability suit was presented for payment. Upon motion of Doctor Gosman and a second by Doctor Popplewell, the statement was approved.

#### **NEW BUSINESS**

A LETTER FROM THE STATE BOARD OF HEALTH CONCERNING THE GOVERNMENT REGULATIONS ON AMPHETAMINE COMBINATION RECALL INFORMATION was reviewed for information of the committee and, by consent, it is to be called to the attention of the Board of Health that it is hoped the Board of Health might distribute this information to all Indiana physicians.

FURTHER DISCUSSION OF VACANCIES ON AMA COUNCILS AND COMMITTEES was discussed by the president and, upon motion of Doctor Gosman and a second by Doctor Dukes, Dr. Jack Hall of Indianapolis is to be nominated for a position on the Council on Medical Education.

ENTERTAINMENT FOR ANNUAL MEETING—Doctor Gosman raised the question concerning entertainment for the annual meeting, pointing out he could obtain Franz Benteler and His Royal Strings and also that Dr. Franklin Bryan had offered the orchestra from the Shrine Club in Fort Wayne and requested the opinion of the committee concerning this program. Upon motion of Doctor Wilhelmus and a second by Doctor Santare, the President was authorized to use his own judgment as to employing which group he preferred.

EMERG-A-CALL LIFELINE TO EMERGENCY MEDICAL INFORMATION by Intercept International, Inc., was discussed by the President, suggesting it be made available to Indiana physicians and they be authorized to use our mailing list for the purpose of explaining it to the members of the Association. Upon motion of Doctor Gosman and taken by consent, this organization will be allowed the use of the mailing list.



FUTURE MEETINGS

UNITED STATES PHARMACOPEIAL CONVENTION—The secretary read a letter from Dr. S. O. Waife, who was unable to attend as official delegate from ISMA to the United States Pharmacopeial, announcing he had sent Mr. John M. Woodside to represent him, for the information of the committee.

A notice of a Conference on Phase III to be conducted in St. Louis, Mo., on April 25, was presented to the committee. Upon motion of Doctor Wilhelmus and a second by Doctor Gosman, no representative will be sent.

Notice of AMA Congress on Medical Ethics to be held in Washington, D.C., on April 26-28, was reviewed and, upon motion of Doctor Dukes and a second by Doctor Gosman, no representative to be sent.

Notice of AMA Congress on Environmental Health to be held in Chicago on April 29-30, was reviewed. Upon motion of Doctor Dukes and a second by Doctor Gosman, no representative will be sent.

Regional Home Health Conference to be held in Chicago on May 1 and 2. By consent, it was agreed to send a representative to be selected by the President.

Conference on Professional Standards Review Data to be held in Chicago on May 10-11, 1973. Upon motion of Doctor Gosman, taken by consent, no representative will be sent.

Notice of AMA Committee on Quackery scheduled to be held in Madison, Wis., on May 12 was reviewed by the committee. Upon motion of Doctor Gosman and second by Doctor Dukes, no representative will be sent.

A notice of workshop to be held in Cincinnati on PAS and MAP was reviewed. Upon motion of Doctor Gosman, taken by consent, no representative will be sent.

NEXT MEETING OF COMMITTEE

There being no further business, the committee adjourned to meet again at 2:00 p.m., EST, Saturday, May 19, 1973.

BOARD OF TRUSTEES

April 14, 1973

The meeting was called to order by Dr. Wilhelmus, chairman, at 5:00 p.m. at the Headquarters Building.

Roll call showed the following:

District Trustee

- 1 Gilbert M. Wilhelmus
- 2 Paul W. Holtzman
- 3 Eli Goodman
- 4 Howard C. Jackson
- 5 Cleon M. Schauwecker
- 6 Paul M. Inlow
- 7 John O. Butler
- 7 Joseph F. Ferrara
- 8 Richard G. Ingram
- 9 William M. Sholty
- 10 Vincent J. Santare
- 11 James A. Harshman
- 12 William R. Clark
- 13 G. Beach Gattman

District Alternate

- 1 Raymond L. Newnum
- 2 Betty J. Dukes
- 3 Thomas A. Neathamer
- 4 William F. Blaisdell
- 5 William G. Bannon
- 6 Glen Ward Lee
- 7 Donald McCallum
- 7 John G. Pantzer
- 8 Jack L. Alexander
- 9 Max N. Hoffman
- 10 Martin J. O'Neill
- 11 Lloyd L. Hill
- 12 Walter D. Greist
- 13 Donald Chamberlain

Officers

- James H. Gosman
- Joe Dukes
- Hugh K. Thatcher, Jr.
- Arvine G. Popplewell
- Frank B. Ramsey

Executive Committee

- Donald M. Kerr
- Vincent J. Santare

AMA Delegates and Alternates

- James A. Harshman
- Eugene Senseny
- Malcolm O. Scamahorn
- Lowell H. Steen
- Jack E. Shields
- A. Alan Fishcer
- Ross L. Egger
- Kenneth O. Neumann
- Thomas C. Tyrrell
- Patrick J. V. Corcoran

Guest

- Lee E. Mortenson

Staff

- |         |                   |         |
|---------|-------------------|---------|
| Present | Robert J. Amick   | Present |
| Present | Howard Grindstaff | Present |
| Present | John L. Walters   | Present |
| Present | Michael McDermott | Present |
| Present | Kenneth W. Bush   | Present |
| Present | Jas. A. Waggener  | Present |

The chairman outlined the meeting, explaining that the Saturday night session was unstructured and was for the purpose of discussing and hopefully coming to some decision concerning several matters, including QAP; the establishment of a foundation corporation on PSRO; peer review; welfare requirements under Public Law 92-603 as it relates to section 230 and 237; an addition to the building; the abortion question; and Blue Shield. Informational materials were distributed for review and information of the Board.

CHAIRMAN: At the last meeting we gave permission to President Gosman to investigate the possibility of filing a class action suit against the federal government on PSRO activities.

DR. GOSMAN: I have gone to the AMA and talked to the legal staff and received no encouragement for a class action suit. As you know, the AAPS has investigated this and has legal counsel investigating the possibility of going ahead. There will be a resolution presented to the Board before this meeting is over, which will come from the Executive Committee.

The matter was further discussed by Dr. Santare, who reported that some areas of the state of Indiana were planning to proceed with the formation of foundations to carry out the PSRO law, further pointing out that 300 or more doctors could get together in any one area and establish a PSRO foundation and if this happened there was not much the Board could do about it.

DR. GOODMAN called to the attention of the chairman that at the February 11th meeting he MOVED that the Board of Trustees at this time go on record as being opposed to the principles expressed in the PSRO section of HR 1, and that the motion was seconded and carried.

DR. GOSMAN then explained the operational chart of the Wisconsin, Illinois and Ohio foundations as they pertained to peer review and PSRO activities.

The matter was again thoroughly discussed by members of the Board.

DR. CHAMBERLAIN MOVED we have already set out guidelines and we are not in favor of the basic idea, however, I think, in contrast to what some



people say, we have an opportunity to control such a program and I feel we should pursue the forming of a necessary foundation and develop some of the guidelines, as I do not think at this point we can just ignore this law.

The motion was seconded by Dr. Thatcher.

DR. CHAMBERLAIN: May I clarify the motion? I wish this Board would go on record authorizing us to develop and implement a PSRO plan under conditions favorable to the physicians of Indiana.

DR. GOODMAN discussed the motion, outlining the results of the survey in his district. He then MOVED I would like to restate as an amendment to this motion that this Board of Trustees of the Indiana State Medical Association is opposed to the principles of PSRO.

The amendment was seconded by Dr. Thatcher.

CHAIRMAN WILHELMUS: The first part of the motion is that we will go on record as being against the PSRO concept and continue to fight PSRO.

This portion of the motion was put to vote on a roll call and carried 14-2.

CHAIRMAN WILHELMUS: The second part of the motion is that we are against PSRO but for us to go ahead and form a foundation so as to be prepared to help sister members if we are forced into this situation.

DR. CHAMBERLAIN: May I read my motion? It is to develop and implement a PSRO plan under conditions favorable to the physicians of Indiana.

The motion was further discussed.

DR. INGRAM: I MOVE that we table this discussion for a period that extends to the next board meeting.

The motion to table was put to vote and carried on a vote of 8-7.

DR. INGRAM: I MOVE that we, the ISMA, give support to this suit being filed by the National AAPS and funds to an upper limit (leave open) to support that suit so long as our name appears on the suit as against the concept of PSRO.

The motion was seconded by Dr. Gosman and the motion was further discussed by members of the Board.

DR. INGRAM: I MOVE that we table this motion until the next meeting.

The motion was seconded.

DR. SANTARE: It seems to me that we are making little progress on resolving some of the problems that we were called together to discuss this evening. The idea of tabling of the motions to come to some condition seems to make it impossible for us to get any place. I was under the impression, which

I believe this Board approved, that we turn this matter of foundations and PSRO over to the Future Planning Committee to draw up a paper foundation for our review.

A parliamentary discussion then took place, resulting in Dr. Jackson MOVING to table Dr. Ingram's motion.

It was seconded by Dr. Goodman, put to vote and carried.

The next matter discussed was that of a statement of policy of ISMA on abortion. The statement prepared by Dr. Gosman immediately following the Supreme Court decision was read, as well as the statement of the American College of Obstetrics and Gynecology. Quite a lengthy discussion then ensued regarding the philosophy of abortions and the philosophy of whether or not the ISMA should take any position in coming out with a strict policy statement on this subject.

DR. THATCHER: I MOVE that we preface Dr. Gosman's formal statement that it is only reasonable for a physician to relate to his patient by advising her whether surgery is sound, anesthesia is sound, or whether she would be a suitable risk for an abortion and counseling both mental and physical prior to abortion.

The motion was seconded by Dr. Inlow.

A lengthy discussion then ensued and finally Dr. Goodman MOVED that the discussion be terminated with no further action and the motion by Dr. Thatcher be tabled until the next Board meeting. The motion was duly seconded, put to vote and carried. The motion was tabled.

The secretary then reported on a meeting held by the State Department of Public Welfare concerning implementation of Sections 230 and 237 of Public Law 92 - 603 which, according to law, must be implemented in the state of Indiana by July 1 or the State Welfare Department will lose one third of its Federal income for the support of these programs.

No action was taken on his comments.

CHAIRMAN: We will next hear from Dr. Thatcher, Chairman of the Building Committee.

DR. THATCHER: Your Building Committee has not made any moves regarding the building question but I can report to you that the association is bursting at the seams at the present time. We have no room for any additional staff people, should we need them, and as we continue to add programs to the association's activities we need more

space for carrying out the objectives which the House and the Board had in mind. I remind you that in our present building we had to reduce our original ideas and the building is not constructed so that we can add an addition on top of the existing structure without building a superstructure of steel work on the outside of the building. It would appear that the only thing we can do then is to add to the rear of the building, which was in the original plans anyway. Your committee feels that they need some expert advice; therefore, Mr. Chairman, I would MOVE that the Building Committee be empowered to obtain the services of an architect to draw plans with the fee to be paid from the building fund. The motion was seconded by Dr. Clark, put to vote and carried.

CHAIRMAN: We will next discuss the Blue Shield Board question concerning the enlargement of the Board. I attended a recent meeting of the Board as a guest and I think it would be wonderful if every Trustee could attend one of the Blue Shield Board meetings.

We have had the question of expansion of the Blue Shield Board before us on several occasions. We have, at this point, felt that the Blue Shield Board should not be expanded, and I would therefore like to ask permission to have the physician members of the Blue Shield Board who are nominated by this Board to attend our next Board meeting for a frank discussion of this question.

The action of the Blue Shield Board was discussed by several, not only as related to expansion of the Board but as to the creation of HMOs in the State of Indiana. As pointed out, the Blue Shield Board at their last meeting voted to approve a change in the Constitution and Bylaws with the agreement of the State Medical to increase the size of their Board by adding three additional consumer representatives. However, this matter must lay over until the July meeting before final action is taken.

Further discussion of this matter took place and Dr. Ferrara MOVED to invite all of the physician members of the Blue Shield Board to meet with the Indiana State Medical Board of Trustees at their next meeting. This was seconded by Dr. Schauwecker, put to vote and carried.

DR. CHAMBERLAIN: Mr. Chairman, I have a short item of business which I would like to bring up at this time and that is I feel that communications must be improved between the state Commission activity and the county and district societies. I would like to see a requirement that members of the Com-



missions attend each of the district meetings and give a report as to what the Commissions are doing. The matter was discussed by several and Dr. Goodman MOVED that it be the responsibility of the trustee to go to the district president and request that they place these individuals on the agenda for the district meeting. The motion was seconded by Dr. Gosman, put to vote and carried.

#### REPORTS OF DISTRICT TRUSTEES and requests for remission of dues:

**DISTRICT 1:** Dr. Wilhelmus announced that the district meeting would be held on the 24th of May at the Rolling Hills Country Club at Evansville. The meeting will start at 6:00 p.m. with dinner being served at 7:00 and a business meeting immediately following the dinner. The Honorable Otis R. Bowen, Governor of the State of Indiana, will be the speaker for the evening.

**DISTRICT 2:** Dr. Holtzman reported that their meeting will be held on May 17 at the Inn of the Four Winds on Lake Monroe, with the meeting beginning at 4 o'clock in the afternoon.

**DISTRICT 3:** Dr. Goodman reported that the Third District would meet on Wednesday, September 26, at the Elks Club Golf Course and Marriott Hotel at Clarksville, with the program starting at 4 o'clock.

**DISTRICT 4:** Dr. Jackson announced their meeting would be held on May 9 at 4:00 p.m. and would be held at the Otter Creek Country Club at Columbus, with the meeting starting at 4:00 p.m.

**DISTRICT 5:** Dr. Schauwecker announced that their meeting would be held Wednesday, May 23, at the Windy Hill Country Club at Greencastle, with the meeting starting at 4:00 p.m.

**DISTRICT 6:** Dr. Inlow stated their meeting would be held Wednesday, May 2, at the Durbin Hotel in Rushville, with the business meeting starting at 3:30 in the afternoon.

**DISTRICT 7:** Dr. Ferrara reported that their meeting will be held on Wednesday, June 20, at the Speedway Motel and Golf Course and that the meeting time has not been selected as yet.

**DR. FERRARA:** I also move the remission of dues of three members of our district. The motion was seconded, put to vote and carried.

**DISTRICT 8:** Dr. Ingram announced their Meeting would be held on Wednesday,

June 6, at the Green Hills Country Club in Muncie. There will be golf in the afternoon with the business meeting at 6:00 p.m. and following the business meeting there will be a dinner at which Jack Benny will be the speaker at \$30.00 per person for the dinner.

**DR. INGRAM:** I would also like to move the remission of dues for a doctor in my district. The motion was seconded, put to vote and carried.

**DISTRICT 9:** There was no representative present from District 9, but it was noted that their meeting is scheduled for Thursday, June 14, to be held at the Big Pine Country Club and Hotel Attica in Attica, with the meeting starting at 4:00 p.m.

**DISTRICT 10:** Dr. Santare reported their meeting would be held Wednesday, May 30, at the Lake of the Four Seasons Country Club southwest of Valparaiso, with the business meeting starting at 5 o'clock. The charge will be \$10.00 per person for the dinner.

**DISTRICT 11:** Dr. Harshman reported that their meeting would be held Wednesday, September 19, in Marion, inasmuch as the Grant Country Medical Society was celebrating its 125th anniversary and this is the oldest county medical society in the state. The location of the meeting will be for golf at the Marion Meshingomesia Country Club and Emley's Restaurant.

**DISTRICT 12:** Dr. Clark announced that their district meeting would be held on September 13 at the Pine Valley Country Club and Win Shuler's Restaurant in Fort Wayne. The meeting will begin at 5 o'clock in the evening. Everyone is welcome.

**DR. CLARK:** I would like to move the remission of dues of a member of my district. The motion was seconded, put to vote and carried.

**DISTRICT 13:** Dr. Chamberlain: Our meeting will be held on September 12 at the Plymouth Country Club and the American Legion Hall in Plymouth, the meeting starting at 4:00 p.m.

The secretary announced that the Tel-Med program, which has been operating four weeks as of April 14th, has recorded a total of 10,196 calls; the peak for any one day was 787.

There being no further business, the meeting was recessed until 9:00 a.m., Sunday, April 15.

## BOARD OF TRUSTEES

April 15, 1973

The Board of Trustees meeting was called to order at 9:05 a.m., Sunday, April 15, 1973, at the Headquarters Building by Chairman Wilhelmus.

Roll Call showed the following:

District	Trustee	
1	Gilbert M. Wilhelmus	Present
2	Paul W. Holtzman	Present
3	Eli Goodman	Present
4	Howard Jackson	Present
5	Cleon M. Schauwecker	Present
6	Paul M. Inlow	Present
7	John O. Butler	Present
7	Joseph F. Ferrara	Present
8	Richard G. Ingram	Present
9	William M. Sholty	Absent
10	Vincent J. Santare	Present
11	James A. Harshman	Present
12	William R. Clark	Present
13	G. Beach Gattman	Absent

District	Alternate	
1	Raymond L. Newnum	Absent
2	Betty J. Dukes	Absent
3	Thomas A. Neathamer	Absent
4	William F. Blaisdell	Present
5	William G. Bannon	Absent
6	Glen Ward Lee	Present
7	Donald C. McCallum	Absent
7	John G. Pantzer	Absent
8	Jack L. Alexander	Absent
9	Max N. Hoffman	Absent
10	Martin J. O'Neill	Present
11	Lloyd L. Hill	Present
12	Walter D. Greist	Absent
13	Donald S. Chamberlain	Present

Officers	
James H. Gosman	Present
Joe Dukes	Present
Hugh K. Thatcher Jr.	Present
Arvine G. Popplewell	Present
Frank B. Ramsey	Present

Executive Committee	
Donald M. Kerr	Present
Vincent J. Santare	Present

AMA Delegates and Alternates	
James A. Harshman	Present
Eugene F. Senseny	Absent
Malcolm O. Scamahorn	Absent
Lowell H. Steen	Absent
Jack E. Shields	Present
A. Alan Fischer	Present
Ross L. Egger	Absent



Kenneth O. Neumann	Absent
Thomas C. Tyrrell	Present
Patrick J. V. Corcoran	Absent

#### Guests

Mr. David Johnson	Present
Robert M. Reid, M.D.	Present
Hon. Roger Zion	Present
Wm. Paynter, M.D.	Present
Joe M. Black, M.D.	Present
Mr. Richard Kilborn	Present
Richard Bloomer, M.D.	Absent
Hanus Grosz, M.D.	Present
John G. Suelzer, M.D.	Present
Dwight Schuster, M.D.	Absent
Mr. Lee Mortenson	Present

#### Staff

Robert J. Amick  
Howard Grindstaff  
John L. Walters  
Michael McDermott  
Kenneth W. Bush  
Jas. A. Waggener

The Chairman introduced William Paynter, M.D., new Secretary of the Indiana State Board of Health, who had been invited to appear before the Board to make the usual report so that the Board would be fully informed on plans in process at the Board of Health.

DR. PAYNTER discussed major organizational changes, continuing efforts with HEW, reassigned health systems, state environmental programs, and a substantial approach to develop a system of county regional health departments throughout the state. In discussing comprehensive health planning, he stated he thought health planning should be done primarily by health professionals but also shared with other individuals. My efforts, he said, will be directed toward coordinating the public health sector with health delivery systems.

When asked if he thought it necessary to have a certificate of need, he stated he could see no reason for one in Indiana at the present time and would rather put his hopes in a planning process.

CHAIRMAN: Thank you, Dr. Paynter. I will now call on David Johnson, who is the Executive Director of the Evansville Deaconess Hospital. Deaconess Hospital has been computerized for eight years and is one of the largest computer complexes in the United States. The other two large centers are Miami Beach and Beaumont, Texas. The installation of this system in Evansville required 2.5 million dollars, with all functioning activities of the hospital connected into the

Medical Information Processing Service System.

MR. JOHNSON: Computer operation is growing rapidly and 90% of the larger hospitals now have it in some form. "We recognize that hospital costs are going up rapidly, so to stop increasing costs—we do not expect to reduce costs—we had to find a way to reduce people interface." He stated it is always necessary to change the attitude of the medical staff since it is hard to wean them away from paper and to rely on the computer. He quoted the vice president of General Motors as saying, "The world hates to change, yet it is the only thing that has brought about progress."

Advantages cited: It can do a better job, is more sophisticated, more productive and cheaper for the patient, gives clues as to diagnosis, more functional and effective methods and has an important by-product of statistics gathering. After implementation, the computer service saves hard dollars and "If you can spend money today to save money tomorrow, it is a good investment."

Mr. Johnson then answered questions and made special reference to the reprints of eight articles in the Washington Post dealing with the expose of supposedly corrupt ethics of hospitals in the D.C. area. He said every Congressman receives copies and there is great trauma. The total facts are not told.

CHAIRMAN: Thank you, Mr. Johnson. I now recognize Dr. Santare.

DR. SANTARE: I MOVE that copies of the reprints of the articles appearing in the Washington Post be ordered for distribution to the trustees, alternate trustees, and the AMA delegation.

The motion was duly seconded, put to vote and carried.

CHAIRMAN: I will now call on Dr. Robert Reid of Medi-Tech for a discussion of their system.

DR. REID spoke of the 83% owned organization of Medi-Tech, which is addressed to the principle of automated patient histories, and explained how a properly conducted history (1) must be a time-saving service for the physician, (2) must improve the quality of patient records, (3) must be subject to retrieval and transfer, and (4) must remain the tool of the physician and under his control.

Acceptance among patients has been high, so this is not a major problem; however, it is a major effort and requires heavy physician participation plus the fact that if the information is not periodically updated, a lot of money and patient time is wasted. He also said the

physician will hear more and more about hospital information centers; these are hospital oriented systems with benefits indirect to the physician. We need to think about patient-oriented data basis under management of physician structure which are attributed to the patient wherever they are and whatever they are doing.

Since Medi-Tech is a service to the physician, no doctors need subscribe to it until they have been exposed to it for 90 days with no capital outlay.

CHAIRMAN: Thank you Doctor Reid. We will now hear from Roger Zion, Congressman of the 8th District.

CONGRESSMAN ZION discussed the federal programs as applying to medicine with a greatly increased federal need for participating in community programs, also a crying need for federal funds—"63 million dollars a day doesn't do it." The worst problem confronting us now is inflation and there is a bill, which will probably pass, in regard to rolling back prices and fees to March 16. He discussed the two HMO bills, and said there would probably be no major change in national health insurance until '74, the election year, at which time it might be something to watch. Also discussed were HCC (Health Care Corporation), Mediscredit and peer review.

DR. GOSMAN asked Representative Zion if he thought ISMA should file an action suit, if for no other reason than to bide for time, since it was felt that PSROs were discrimination. He answered that he was against class action suits because in most instances it is force; the concept is not good and should be the last resort—a reasonable compromise is much preferable.

DR. GOSMAN then asked, "We are skeptical of forming and implementing PSRO, should we be prepared on paper with the necessary organizational structure to carry out the dictates of the law?" Representative Zion answered that he thought it best to do this—to at least go through the motions that the ISMA is trying to cooperate. He thought Dr. Gosman's point to be more pertinent on Phase III discrimination.

CHAIRMAN: We will now receive the report from Dr. Black, Chairman of the Board of Blue Shield.

DR. JOE BLACK: I am here today to seek approval of the Trustees on two matters which were voted on at the last meeting of the Blue Shield Board. The first item has to do with service agreements with HMOs in Indiana.



The second item is the expansion of membership on the Blue Shield Board.

Dr. Black was asked where the HMOs were located, and he replied they were in Lawrence County, Bedford; one in Lake County and one in St. Joseph County.

DR. KERR: I would like to state that within the last 24 hours there is no HMO in Bedford. The physicians have not signed an agreement and the research grant which was made to us was for the study of an HMO in the locality only.

DR. BLACK then presented the following points:

1. We know that HMOs will come into existence, especially in the welfare programs.

2. We are not trying to sell or push an HMO. We want the right, with the agreement of State Medicine, to negotiate to learn what we can do about it, and to keep you informed of what the performance of the HMO will be.

3. We are not sanctioning HMOs but are only offering our administrative services—we are to pay the bills, pay the provider to collect fees.

4. G.M. is offering the HMO plan to their employees. Since G.M. is already under contract to Blue Shield, they would be losing business if they did not participate.

#### IN REBUTTAL:

1. The ad hoc committee had previously made certain recommendations which are not in line with what the Blue Shield Board now wants to do.

2. The ISMA Board opposes HMOs and several of the trustees did not want to see Blue Shield become involved, even if it meant losing business.

Following a lengthy discussion, Dr. Goodman MOVED that "when the Blue Shield representatives are under the immediate pressure of making an agreement, or no agreement with an HMO, let them come back to us with all specifics of the situation. We will then either give approval or disapproval." The motion was seconded by Dr. Gosman.

DR. GOSMAN then MOVED an amendment to the motion that the following be added "the physicians in the state of Indiana are unalterably opposed to the concept of HMOs." The amended motion was then seconded and carried. The main motion as amended was put to vote and carried.

DR. BLACK: The second item is that

the Blue Shield Board voted approval to increase the size of the Blue Shield Board by adding three consumer members. This was a recommendation of the proxy committee at the annual meeting. Currently the Board is comprised of twenty physicians and five consumer members. The proposal was to have twenty physicians and eight consumer members.

The proposal was thoroughly discussed and, following the discussion, Dr. Jackson MOVED that the ISMA Board of Trustees go on record as being opposed to increasing the Board of Directors of Blue Shield. The motion was duly seconded. Dr. Goodman then proposed an additional statement which he felt would be in a positive vein by saying "this Board is in favor of maintaining the present number of members of the Blue Shield Board." The editorial change was accepted by Dr. Jackson and the second and was then put to vote and carried.

The Board then recessed for lunch.

CHAIRMAN WELHELMUS: I will now take up the minutes of January 20, and 21 and February 11.

A request was made to make a correction on page 5 of the blue sheet where it says we should "keep praising I.U. School of Medicine" and it was inferred that we should keep praising the increase or build up in the number of medical students each year. I think we should all agree that we should keep encouraging the I. U. School of Medicine as they are doing a great job. On motion duly made and seconded, the minutes were approved as corrected.

CHAIRMAN WILHELMUS: I will now call upon Mr. McDermott for a report on the legislative activities.

MR. McDERMOTT presented copies of updated information on the 104 bills the Association is currently interested in following. Statistically, of the 104 bills, some 74 were being looked at from an informational standpoint. Of the 74, 26 look like they will be passed and signed into law by the Governor, and 40 of them failed. Fifteen bills had the Association's strong support, of which 7 will become law and 8 will have failed in this session. The Commission on Legislation has agreed to present a legislative platform at the annual meeting of all the bills the Association is interested in so that the House of Delegates will be able to review them. He reported the only bill, House Bill 1169, which would require physicians and others to report all cancer cases to the Board of Health,

as yet we have been unable to get changed. On MOTION of Dr. Gosman and a second by Dr. Schauwecker, the Board commended Mr. McDermott for a job well done.

CHAIRMAN WILHELMUS: We will now have the president's report.

DR. GOSMAN reported on the Tel-Med program pointing out that the public acceptance of this program was one of unqualified enthusiasm and support and that requests were being received from the public to extend the hours.

DR. GOSMAN then reported he felt a closer liaison was established and pertinent information received during the recent meeting of the executive secretaries of the component county societies with the headquarters staff and the president. He then MOVED that the ISMA initiate through the headquarters office at least three or four such meetings during the coming year with the executive secretaries of the county medical societies, the program to be devised by the president and president-elect. The motion was duly seconded, put to vote and carried.

DR. GOSMAN then reviewed the Student-Faculty-ISMA Retreat held in Nashville recently and informed the trustees that, after the findings had been compiled, the report will be made available to the officers of the Association. During the course of the meeting, he pointed out, it was reported that 51% of our graduating seniors will stay in Indiana for their internship and residency programs.

DR. GOSMAN then spoke of the AMA's Medcredit Bill and pointed out he felt the Association should lend its support and approval to the concept of this proposed legislation. He then MOVED that the ISMA Board of Trustees go on record as approving the AMA Medcredit Bill in its present concept. The motion was seconded by several, put to vote and carried.

DR. GOSMAN then related to a proposal presented to the Commission on Medical Economics and Insurance at its meeting on Sunday, March 4, by Mr. Harold Parham, executive vice president of the Florida Medical Association. The Florida Plan, in a nutshell, is that they have organized a for-profit stock corporation for the handling of malpractice insurance. Under their plan the broker has 41% of the stock and the Florida Medical Association holds 49%. He stated they plan to expand this program to cover all forms of insurance offered



to the membership by the Florida Medical Association. The Commission was very enthusiastic about this program, inasmuch as Florida felt they had an opportunity to have additional income of \$100,000 or more for the Association under this plan. The Commission feels they should further investigate this and they are asking this Board to give its approval of their report and to empower them to continue further their investigation of this plan. Dr. Gosman then MOVED that the ISMA trustees approve the report of the Commission on Medical Economics and Insurance and approve their continued investigation of this matter for presentation to the House of Delegates in October. The motion was seconded by Dr. Schauwecker, put to vote and carried.

PSRO—Dr. Gosman pointed out that one of his concerns as president of ISMA is the matter of PSROs. He said, "I can see splitting of the Association should we not form an umbrella organization and assume the chief responsibility of implementation and conduct of this program. I can see various counties and regions going off on their own forming PSROs but I feel that the ISMA should take the leadership as an umbrella organization and sub-contract this activity back to the local level. I feel it is so important that we be ready that I would plan a special meeting of the House of Delegates strictly for a discussion of this concept and hopefully gain their input into our thinking in this area."

Secondly, in regard to Blue Shield matters, I am still upset by their letter writing and think the Blue Shield Board should control the content of these letters.

The president's comments were discussed.

DR. SANTARE MOVED the Board's reconsideration of inviting only the six members of the Blue Shield Board who were nominated by the Indiana State Medical Association.

The motion for reconsideration was seconded by several, put to vote and carried.

DR. SANTARE: I now MOVE we ask the six Blue Shield Directors who are nominated by this Board of Trustees to meet with us on Sunday, May 20. The motion was seconded, put to vote and carried.

CHAIRMAN: We will now hear from Dr. Ramsey, editor of *The Journal*.

DR. RAMSEY: Mr. Chairman, Trustees, *The Journal* is doing well except in one department, probably the most important department, and that is our

advertising revenue. The years 1971 and 1972 were neither one very lush with advertising but they were what you might call barely satisfactory. So far this year the advertising for the whole group of state journals is down about 25%. I would urge you, as trustees, to write letters of appreciation to the advertisers in our journal in order to help promote journal advertising. Thank you.

#### MATTERS REFERRED BY THE EXECUTIVE COMMITTEE:

DR. KERR: We have a request from the Woman's Auxiliary to the Student American Medical Association asking us for financial help; they request \$50 to assist them in their activities.

DR. FERRARA MOVED that the contribution of \$50 be made. The motion was seconded and carried.

DR. KERR: The next item is a request from Sarkes Tarzian relative to the Eisenhower Memorial Scholarship Foundation. They are requesting that ISMA sponsor a scholarship of \$8,000 for a four-year period.

DR. HARSHMAN MOVED to answer their letter by telling them our efforts are directed towards medical education; however, we appreciate the opportunity to participate.

The motion was seconded by Dr. Santare, put to vote and carried.

DR. KERR: Your committee refers to you the matter of organizations—two of them, in fact—the American Health Profile Group and another one out of Illinois that are coming into this state to do multiphasic screening. They have contracted with labor unions particularly to do a complete health examination for a fee of \$45. Mr. Waggener has checked this out with the State Board of Health and also with the Medical Board and it seems as though these groups are operating legitimately as far as the Medical Board and the State Board of Health are concerned. He has also discussed this with Jefferson County, Kentucky, and with the Ohio State Medical who have established guidelines governing this type of operation.

DR. GOSMAN MOVED that this matter be referred to a committee of his selection for discussion and a review. This was seconded by Dr. Santare, put to vote and carried.

DR. KERR: Our secretary brought to our committee a problem for which apparently we have no solution. This is in regard to physicians who are coming into our state under the Public Health Service Act as to what we do with them

as far as membership status and dues are concerned.

Your Executive Committee recommends that the Public Health doctors be put on the basis that the military physicians are with regard to not paying dues. Mr. Waggener has explained to us that the ISMA Constitution and Bylaws has no classification for military membership.

Upon motion by Dr. Goodman, seconded by Dr. Ferrara, this matter was referred to the Membership Committee.

DR. DUKES then MOVED that they reconsider this decision. Seconded by Dr. Thatcher, put to vote and carried.

DR. THATCHER then MOVED that anyone in this category (1) cannot hold state office or (2) chair state committees but (3) may hold county office if the county so decides, and (4) taken in as non-dues paying members who cannot hold office in the state organization but leave it up to the individual counties as to whether or not they can hold office. This motion was then seconded, put to vote and carried.

DR. KERR: We have another membership problem. We need a policy on this with respect to calculating the delegate strength of a particular county at our state meeting. We feel that a policy should be established whether interns and residents and military people who pay little or no dues should be considered in allocating delegate strength in respective counties.

This was discussed by several and Dr. Gosman then MOVED to have this referred to the Commission on Constitution and Bylaws for study and that they in turn submit to the House their opinion. The motion was seconded by Dr. Schauwecker, put to vote and carried.

DR. KERR: We have another item here on which we can spend an hour or which we can refer to a committee very quickly. We have had repeated discussions on some effort to establish legislation relative to the Sick Doctor Statute. Dr. Kerr then read an opinion from the State Board of Medical Registration and Examination and from the Attorney General.

Following discussion, it was MOVED by Dr. Goodman that this be referred to the Ad Hoc Committee on the Medical Disciplinary Act for recommendations to the ISMA Board and to the Registration Board. The motion was seconded by Dr. Santare, put to vote and carried.

DR. KERR: The next item deals with the Workman's Compensation law. It is now necessary for a physician, as an



employer, to either carry Workman's Compensation insurance or obtain a certificate from the Industrial Board stating that the physician has resources to handle any employee's accident or injury on the job. In other words, a physician-employer is responsible for his employees and this is a necessary safeguard. This was further discussed and taken as a matter of information, with the secretary instructed to put this information in the next Newsletter.

DR. KERR: Malpractice. It was important, I believe, for you to know how many malpractice suits are initiated, resolved out of court, thrown out, etc. in the state of Indiana so that we will know what to do about medical defense funds. In Alabama the law is that any physician, with such an action brought against him, shall file a report with the Board of Medical Registration of the state. The general opinion of the Executive Committee was that this might be a good thing for us to initiate in Indiana so that information would be available. It was moved and seconded that this be done and Dr. Harshman then amended to include in this the proposal initially instituted by Florida concerning the malpractice contract. The amendment was accepted and the motion put to vote and carried.

DR. KERR: I would like to call your attention again to the vacancies on the AMA Council and Committees and nominations are now in order and I would hope that the trustees might give recommendations to Mr. Waggener.

DR. KERR: We have a resolution on Phase III presented by Dr. Harshman regarding a resolution be put in the AMA House of Delegates calling for the AMA on behalf of its members to cause to be filed a class action suit against the federal government regarding discrimination against the medical profession in the Phase III guidelines which it has imposed on physicians. The fiscal note estimated the cost to the AMA of \$250,000.

DR. HARSHMAN MOVED, seconded by Dr. Goodman, to have a resolution introduced in the House of Delegates of the AMA in regard to a class action suit in regard to Phase III. The motion was put to a vote and by a show of hands lost on a vote of 7 - 6.

DR. KERR: We also have a resolution from the Commission on Special Activities. It follows: "Be it resolved, inasmuch as a family physician has been decreasing in population yet the current student in medical training evidenced a greater interest in family practice over

other specialties; Be it resolved that the Council on Medical Education be directed to review the number of available residencies in family practice in relation to other specialties, and to consider increasing the number of available residencies in family practice and decreasing those specialty fields that overly represented." The request of this commission is that the ISMA introduce this in the AMA House of Delegates in June.

DR. GOSMAN MOVED, seconded by Dr. Schauwecker, that the resolution be introduced in the AMA House of Delegates in June. The motion was put to vote and carried.

DR. KERR: The next is a resolution from the American Medical Association, as adopted by their House of Delegates, concerning physicians with psychiatric disorders, including alcoholism and drug dependency, and asking that a committee be formed in our association in each county society for referral of these problems.

This matter was discussed in light of previous actions by the Board and Dr. Gosman MOVED that this be referred to the Commission on Medical Education and Licensure and to the Ad Hoc Committee. This was seconded by Dr. Goodman, put to vote and carried.

DR. KERR: The last item is a memorandum from the State Board of Health relative to the recall of amphetamine combinations.

This matter was taken as a matter of information and the information is to be placed in *The Journal*.

DR. KERR: The Committee on Sports and Medicine is unhappy with the action of the Board taken previously in ordering the questionnaire placed in *The Journal* rather than in a direct mail to the physicians in this state. The committee has now asked that a mailing be sent, which was reported to cost approximately \$300, to the entire membership.

DR. SCHAUWECKER MOVED that the questionnaire be placed in the Newsletter with a postpaid card included for a return answer. The motion was seconded by Dr. Clark.

DR. LEE then MOVED that this inquiry be sent to the secretaries of county medical societies. Following discussion, Dr. Lee withdrew his motion in favor of the original motion which was then put to vote and carried.

DR. KERR: Regarding the report by the president of the success of the Tel-Med program that we have experienced some 10,000 calls in a month's time, and regarding the request for changing the

hours of operation to include up until 8:00 p.m. and also on Saturdays, in order to give people who are busy working a time to avail themselves of this service, and this of course would require additional people.

The matter was discussed by Mr. Waggener who gave an estimate of the cost of extending the hours and, following this discussion, Dr. Santare MOVED that further study be given this matter and we rediscuss it after a three-month period. The motion was seconded by Dr. Schauwecker, put to vote and carried.

CHAIRMAN WILHELMUS: We will now have the treasurer's report.

DR. THATCHER reviewed in detail the transactions of the association and following the review, upon motion of Dr. Thatcher and seconded by several, the report was approved.

CHAIRMAN WILHELMUS: We will now have reports from our various commissions.

COMMISSION ON SPECIAL ACTIVITIES—Dr. Hanus Grosz.

DR. GROSZ reported his concerns in the area of drug abuse, with the present situation in the area of heroin addiction, intervention of the federal government in the treatment of drug addiction and the fact that physicians in practice can no longer prescribe methadone even though lay persons in charge of drug abuse centers can.

Methadone has, in itself, become a major element of abuse, he said. We need to take some approach where addiction can be treated without narcotic agents. Propranolol is a non-addictive narcotic antagonist.

(1) If patients who take this medication shoot heroin while taking propranolol, they experience no euphoric effects—just like shooting water.

(2) Addicts who take heroin while on this medication experience unpleasant withdrawal.

(3) Heroin addicts who have been withdrawn on propranolol lose their craving for narcotics, as opposed to methadone treatment.

Propranolol should be independently tested; however, the federal government has obstructed opportunities to do research and has ignored the tests done so far. The Commission on Special activities has voted unanimously to place this before the Board of Trustees. Dr. Grosz said he hoped the Board would take an official stand and support attempts to provide treatment; the Board could also express concern about federal intervention.



Following discussion, Dr. Gosman **MOVED** that ISMA take every avenue of approach they can to try to reach some satisfactory conclusion. Dr. Goodman then suggested a stronger statement to the effect that "Where one of our members appears to be working with an agent to help solve the problem of addiction, so that blocks may be removed and tested fairly, etc. etc." Dr. Gosman then withdrew his motion and seconded Dr. Goodman's statement. The motion was then put to vote and carried.

**CHAIRMAN WILHELMUS:** We will now call on John G. Suzelzer, Chairman of the Commission on Emergency Medical Services.

**DR. SUELZER:** My commission feels something has to be done in regard to Emergency Services legislation. Dr. Farquhar has suggested taking the AMA guidelines for establishing an Emergency Medical Services Council on a statewide basis which would be called into session by the ISMA and would consist of representatives from various groups so as to obtain needed legislation.

Following discussion, it was **MOVED** by Dr. Schauwecker and seconded by Dr. Butler to approve the commission's recommendation and the motion was then put to vote and carried.

**CHAIRMAN WILHELMUS:** We will now hear from Lee Mortenson, field representative of the AMA.

**MR. MORTENSON** announced that there will be proposed at the June meeting a model constitution and bylaws for a county medical society. Following this report it was **MOVED** that the ISMA be provided with the AMA bylaw changes as soon as possible. The motion was seconded, put to vote and carried.

**CHAIRMAN WILHELMUS:** We will now have a report of the Board Committee on Economic and Fiscal Matters.

**DR. GOODMAN:** Our committee feels that the \$30,000 requested by the Commission on Public Information for an accelerated PR program was of such magnitude that it should be submitted to the House of Delegates. In regard to the Speakers' Bureau, Dr. Goodman said they discussed the funding on an interim basis before the House meeting, but no funds could be found.

**DR. GOSMAN** **MOVED**, seconded by Dr. Jackson, that the recommendation of the Commission on Public Information be submitted to the House of Delegates with a fiscal note.

Following additional discussion, Dr. Gosman then withdrew the motion and

Dr. Harshman suggested referral back to the committee for another meeting with Mr. Waggener, Dr. Dukes and Dr. Thatcher. It will again be reported to the Board, who should then take the responsibility of presenting it to the House of Delegates.

**CHAIRMAN WILHELMUS:** We will now hear from the Ad Hoc Committee For Study of Steamlining the Annual Convention.

**DR. SANTARE** reported in the absence of Dr. Inlow. He also brought up the fact that the students attending the Retreat would like to have a seminar in regard to the economics of running a medical office and would like to have something on disability insurance and malpractice insurance.

**CHAIRMAN WILHELMUS:** We will now hear the report from the Commission on Medical Education and Licensure.

The action of the commission was then read showing that Dr. Egger had **MOVED** that the commission recommend that the QAP program be assigned to an appropriate commission for study and to make a recommendation back to the house of Delegates at their next meeting.

**DR. HARSHMAN:** I **MOVE** that we refer this back to the commission so they can take it to the House of Delegates. The commission is also to be informed that the Board has previously taken a stand with respect to QAP.

The motion was seconded by several, put to vote and carried.

**DR. GOSMAN**, then **MOVED** to grant authority to the Commission on Medical Education and Licensure to charge a fee for continuing medical education services so they would be self-sustaining. The motion was seconded by Dr. Butler, put to vote and carried.

**CHAIRMAN WILHELMUS:** We will now call on Dr. Gosman for a report on the Medical Historical Museum.

**DR. GOSMAN** then explained the background of the Medical Historical Museum and the status of the effort to preserve the old Pathology Building at Central State Hospital. He pointed out that the Indiana Medical Historical Foundation discussed the future and advised the Board of the following actions of the foundation:

(1) That the IMFHF be changed from a private to a public foundation in order to become exempt from income taxes. This step would require legal action to enable the general public to contribute

to the foundation. Along with this the foundation should be enlarged by taking in the ISMA committee and by additional ISMA members to broaden the foundation base.

(2) Liaison has been established with the Indiana Historical Society and the John Shaw Billings Society, which is a medical historical society.

(3) Steps are on the way to seek financial support from either the Lilly Foundation or the Lilly Endowment. This would be in the form of a one-time grant and not an ongoing contribution.

(4) Purposes, means and goals are outlined on the attached sheet which I will not go into, and, in summary, your committee seeks your approval and support for these recommendations.

On **MOTION** of Dr. Gosman, seconded by Dr. Butler, the recommendations were approved.

**CHAIRMAN WILHELMUS:** Dr. Shields has presented us with a resolution which he would like to see the ISMA introduce in the AMA House of Delegates. You will have a copy so I will not read it.

The resolution was then discussed and, on **MOTION** of Dr. Santare, seconded by Dr. Schauwecker, it was **MOVED** that we accept the idea in principle and recommend that the resolution be rewritten and a fiscal note be prepared for attachment.

## EXECUTIVE COMMITTEE

May 19, 1973

The Executive Committee was called to order at 2:00 p.m. by Dr. Donald Kerr, chairman, at the Headquarters office on Saturday, May 19.

Roll call showed the following present: Donald M. Kerr, M.D., Vincent J. Santare, M.D., James H. Gosman, M.D., Joe Dukes, M.D., Gilbert M. Wilhelmus, M.D., Hugh K. Thatcher, Jr., M.D., Frank B. Ramsey, M.D., and Jas. A. Waggener. Arvine G. Popplewell, M.D., absent.

**MINUTES OF THE MEETING** held April 14 were approved on motion of Dr. Thatcher, seconded by Dr. Santare.

**THE MEMBERSHIP REPORT** was approved by consent.



Membership report as of April 30, 1973:

Members as of December 31, 1972 . . . .			
	ISMA	AMA	
	4,591	4,246	
		Increase	
		Over	
	1973	1972	4/30/72
ISMA			
Full dues-paying	3,958	3,907	51
Residents	57	51	6
Exempt	482	466	16
TOTAL	4,497	4,424	73
AMA			
Full dues-paying	3,651	3,617	34
Residents	44	4	40
Exempt	482	466	16
TOTAL	4,177	4,087	90
Paid ISMA—not AMA			
Full dues-paying	307	290	17
Residents	13	47	-34
TOTAL	320	337	-17

## HEADQUARTERS OFFICE

**AAPS LUNCHEON DURING CONVENTION** — The request of the AAPS organization to hold a luncheon during the annual meeting in October was approved by consent.

**LEASE ON PROPERTY AT 3920 N. PENNSYLVANIA ST.** — The secretary reported a call he had received from Indiana National Bank concerning the lease on the property located at 3920 N. Pennsylvania in which the occupant had requested a three-year lease with the option to renew for another three years at the existing renewal of \$185 per month. Following a discussion, the secretary was authorized to inform the bank they would look favorably upon a three-year lease with a renewal option provided it is understood by the occupant that: (1) the association might have need for the ground at the rear of the house for expansion of existing facilities of the association; (2) the lease for the current year would remain at \$185; the second year \$195 and the third year up to 5% increase of \$195.

**TEL-MED REPORT** — The secretary reviewed the experience on the Tel-Med activity for March 23 to April 30 for the information of the committee.

**USE OF BUILDING** — The secretary raised the question concerning night meetings being held in the building which required the presence of staff and, following discussion, it was agreed that there should be a charge to all groups for night use of the building of up to \$25 and also an understanding should be had with all groups that the building would have to be cleared by 10:00 p.m. The secretary is further requested to check the possibility of having a Pinkerton man to close at night to relieve staff

of this responsibility.

**WATER SEEPAGE PROBLEM** — The secretary reported he had two contractors figure on the water seepage problem on the east wall of the building and he had one suggestion that the shrubbery would all have to be removed and the ground would have to be excavated and a new membrane put on the basement wall with a guarantee price of \$2900.

He said another contractor had dug down and found what he thought was the problem and that was the basement wall was laid with 12" blocks and slightly below ground level they came up with an 8" block which leaves an area for the water seepage in the 12" blocks. He thought this could be corrected without having to remove the rear stoop, with the cost not to exceed \$500.

The secretary was authorized by consent to arrange with the lower bidder for correction of the problem.

**ORGANIZATION OF STATE MEDICAL ASSN. PRESIDENTS** — The secretary then presented a letter from the Organization of State Medical Association Presidents seeking a membership fee from the association in the amount of \$50. The payment of this amount was approved on motion of Dr. Thatcher seconded by Dr. Gosman.

## TREASURER'S REPORT

**THE TREASURER THEN GAVE HIS REPORT**, which was approved on motion of Dr. Thatcher, seconded by Dr. Wilhelmus. A discussion then ensued concerning the investment of surplus funds and, on motion of Dr. Santare seconded by Dr. Dukes, the treasurer is authorized to invest as much as possible for a two-year period at the highest interest available.

## ORGANIZATION MATTERS

**REQUEST OF WOMAN'S AUXILIARY** — Regarding the request of the Woman's Auxiliary for the association to add to its clipping service items concerning the Auxiliary, the request was approved on motion of Dr. Santare and a second by Dr. Wilhelmus.

The second request from the Auxiliary in which they had asked for the association to give them an additional \$500 for the purpose of getting speakers of repute for their meetings was discussed. On motion of Dr. Thatcher seconded by Dr. Dukes, the secretary is instructed to inform the Auxiliary they did not have this amount of money in the current budget and no funds are available at the present time. It was also requested to state that

the Executive Committee encouraged the Auxiliary to change their meeting date so as to coincide with the annual convention of the Indiana State Medical Association and under this program the state association might be able to assist them in obtaining speakers of the type they desired.

**MEMO FROM ALLEN COUNTY MEDICAL SOCIETY** — The secretary called to the attention of the committee the memorandum from the Allen County Medical Society concerning the announcement of fees for abortions to be provided at the Union City Hospital by two physicians and that this appeared to be in violation not only of ethics but the position of the association, also the Medical Practice Act. A copy of the announcement has been sent to the State Medical Board of Registration. This item was taken as a matter of information.

**OFFICIAL STATEMENT ON VIABILITY** — The secretary stated the Indiana State Board of Health had requested the association to submit a policy statement concerning the viability of a fetus. The secretary reported he had discussed this with Dr. Sprague Gardiner, who made several suggestions. By consent, the secretary is authorized to issue a statement that viability begins after 139 days of gestation beginning with the first day of the last menstrual period or a fetus weighing under 500 grams.

**PHYSICIAN'S REPORTING FORM** — The secretary also showed a copy of the proposed form being prepared by the State Board of Health to be used by physicians reporting abortions performed. This was taken as a matter of information.

**LETTER FROM DR. ROBERT McDUGAL** — A letter from Dr. Robert A. McDougal was read in which he expressed his opinion that the state legislature was incorrect in adopting the provisions of the present abortion law.

**RETAIL CREDIT ACTIVITY** — The secretary reported that a matter was referred to him by a member of the association concerning the activity of the Retail Credit Bureau in obtaining medical records for insurance companies and the committee reviewed some of the material being used. By consent this matter was referred to the Board of Trustees.

**LETTER FROM DR. ROLAND E. MILLER** — A letter from Dr. Roland E. Miller concerning the current discussion as to the use of Tine versus Mantoux test was reviewed and, by consent, referred to the Commission on Public Health.



**LETTER FROM PATIENT CARE SYSTEMS, INC.** — A letter from Patient Care Systems, Inc., concerning problem-oriented approach to patient care was reviewed and taken as a matter of information.

**REPORT ON U.S.P. CONVENTION** — The report filed by Dr. Waife concerning the recent U.S.P. convention was reviewed and the secretary is instructed to attempt to summarize the information and the president was given the authority to request Dr. Waife to appear before the Board of Trustees if he felt it worthwhile.

**LETTER FROM GEORGIA STATE UNIVERSITY** — A letter from the Georgia State University again requesting use of the mailing list for a survey of Indiana physicians was reviewed and the secretary is instructed to obtain a copy of the survey form to be submitted to the committee for approval.

**LETTER FROM THE T.B.-RESPIRATORY DISEASE ASSN.** — A letter from the Tuberculosis and Respiratory Disease Association of Central Indiana concerning a Physicians' Directory of Hospital Services for respiratory disease patients in central Indiana was reviewed and the secretary reported that Dr. Popplewell had called him stating he did not think this publication should be continued.

As a result of this information, on motion of Dr. Gosman seconded by Dr. Wilhelmus, the secretary is authorized to inform this group that this publication should be discontinued.

**CREATION OF ASSESSMENT COMMITTEE** — A letter addressed to Dr. James Carter from a Dr. Nancy Roeske concerning the establishment of an Assessment Committee to be headquartered in the Indiana State Medical Association building for the purpose of reviewing physician needs with communities was read and, on motion of Dr. Gosman and taken by consent, this is to be referred to the Subcommittee on Rural Health of the Special Activities Commission.

**LETTER FROM DR. POPPLEWELL** — A letter addressed to Dr. Wood from Dr. Popplewell concerning the Health Series which recently appeared on WR-TV was reviewed and taken as a matter of information.

**LETTER FROM DR. HARRY SILVIAN** — A letter from Dr. Harry Silvian was read for the information of the committee.

**LETTER FROM MEDICAL ASSOCIATION OF GEORGIA** — A letter from the Medical Association of Georgia

stating they were supporting Dr. John Rhodes Haverty for a position on the AMA Council on Medical Education was reviewed for the information of the committee.

#### **COMMISSION REQUESTS**

**COMMISSION ON PUBLIC INFORMATION** — The minutes of the Commission on Public Information in which they recommended approval of a leaflet on venereal disease to be distributed by Blue Cross-Blue Shield was reviewed and the request of the Commission was approved by consent.

**COMMISSION ON SPECIAL ACTIVITIES** — The action of the Commission on Special Activities concerning a resolution to be presented in the AMA House of Delegates was approved on motion of Dr. Gosman and a second by Dr. Thatcher.

#### **PSRO ACTIVITIES**

**CALLED MEETING BY AMA, WASHINGTON, D.C.** — The meeting called by the AMA to be held in Washington, D.C. May 23 was discussed and, on motion of Dr. Thatcher seconded by Dr. Dukes, it was moved that Dr. Gosman, Dr. Dukes and the executive secretary attend this meeting.

It is to be shown that Dr. Santare and Dr. Wilhelmus voted "nay".

**MINUTES OF CLARK COUNTY MEDICAL SOCIETY 4/17/73** were read for the information of the committee.

**MINUTES OF CLARK COUNTY MEDICAL SOCIETY 5/16/73** were reviewed and referred to the Board.

**LETTER FROM DR. RICHARD E. RIEHL** — A letter from Dr. Richard E. Riehl was read for the information of the committee.

**LETTER FROM DR. GORDON R. MEYERHOFF** — A letter from Dr. Gordon R. Meyerhoff of New York City was read for the information of the committee.

**LETTER FROM DR. CHARLES C. EDWARDS** — A letter from Dr. Charles C. Edwards, assistant secretary for health, Department of HEW. was reviewed for the information of the committee.

#### **AMA MATTERS**

**INTERN-RESIDENT MATTERS** — Several items concerning the ISMA financing the expenses of an intern at the AMA meeting in New York were discussed and, on motion of Dr. Thatcher and a second by Dr. Dukes, it was decided that no representative would be sent at ISMA expense.

**SUSTAINING MEMBERS** — The

memo concerning sustaining memberships for the participation of ISMA in AIMPAC was reviewed and taken as a matter of information.

**AMA MEMBERSHIP RECOGNITION AWARDS** — A letter from the AMA concerning membership awards was discussed and, on motion of Dr. Dukes and seconded by Dr. Gosman, the Auxiliary is to be urged to solicit memberships from non-members of the AMA and if the ISMA, as a result of their efforts, wins the \$2,000 the entire \$2,000 is to be given to the Auxiliary.

#### **CONVENTION MATTERS**

**GUEST LIST** — The secretary asked for a review of the guest list to be invited to the 1973 convention of the ISMA and, on motion of Dr. Thatcher seconded by Dr. Dukes, the same list as used last year was approved, with the addition of the president of the Minnesota State Medical Association.

**PRESIDENT'S DINNER** — The secretary also announced that the President's Dinner is being planned for the Grand Ballroom at the Hilton Hotel rather than the Convention Center, and this arrangement was approved by consent.

**FIFTY YEAR CLUB RESPONSE** — A list of members being inducted into the 50 Year Club was then reviewed as to the selection of an individual to make the response on behalf of the group and this selection is to be left to the president.

#### **INSURANCE MATTERS**

**LETTER FROM BLUE SHIELD** — A letter received by a patient of a physician was then reviewed and, on motion of Dr. Wilhelmus and a second by Dr. Dukes, a copy of this is to be sent to the president of the Blue Shield Board with the request that the President of the Blue Shield Board explain this at the next Board meeting of the association.

**LETTER FROM INDIANAPOLIS PHYSICIAN** — A letter from an Indianapolis physician concerning problems he is having with payment on Medicare patients was reviewed, and this is to be sent to the Marion County Medical Society.

**CERTIFICATION AND RE-CERTIFICATION** — A letter concerning problems a group of doctors were having on certification and re-certification was reviewed and, on motion of Dr. Gosman seconded by Dr. Wilhelmus, this is to be referred to Dr. Harshman, liaison with ISMA and Blue Cross.

**MINUTES, JOINT MEDICAL ADVISORY COMMITTEE** — Minutes of the meeting of the Joint Medical Advisory Committee of Blue Cross-Blue Shield

held March 8 and April 5 and the minutes of the Blue Cross Executive Committee held April 19 were reviewed and taken as a matter of information. The secretary is instructed to duplicate these minutes and distribute them to the members of the Executive Committee.

#### JOURNAL

**LETTER FROM GIBBS-INMAN CO. INC.** — A letter from the printer of *The Journal* announcing an increase in paper stock costs was reviewed and taken as a matter of information, with the sec-

retary being instructed to research the contract between the printer and the association.

#### MEDICAL DEFENSE

A letter from a physician who is being sued for malpractice was reviewed and, on motion of Dr. Dukes, the information was tabled pending further investigation and the president is to speak to the trustee of the district concerning this matter.

A letter from a physician in East Gary who had made application for medical defense and has forwarded a fee sched-

ule for his attorney was reviewed and his application for defense was approved on motion of Dr. Kerr second by Dr. Wilhelmus.

#### NEW BUSINESS

The president then reported on the activities of Health Careers and the research program of Dr. Hanus Grosz on propranolol and the possibility of obtaining from the foundation funds to pursue the Family Practice Residency Program.

There being no further business, the committee adjourned to meet again on the call of the president.

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**FAMILY PHYSICIAN** or Internist wanted to associate in busy practice with surgeon to take over load left by recently deceased physician. If salary desired, will negotiate or help him to start his own practice. Town of 25,000, very modern hospital facilities and office. Reply Box 383.

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**WANTED:** Family physician and Ob-Gyn for hospital-based clinic. Salaries range \$30,000 to \$40,000. Central administrative office handles paper work. Call or write Joseph D. Howard, Howard Clinic, 26th and North St., Logansport, Ind. 46947; 219-753-4932.

**PATHOLOGIST, A.P.** (C.P. eligible), well trained, military service completed, seeks position. Write Box 386, The Journal, 3935 N. Meridian St., Indianapolis 46208.

**MEDICAL DIRECTOR** needed for appliance components business division, General Electric Co. headquarters, Fort Wayne, Ind. Occupational medicine experience desirable but not mandatory. Good hours, salary, fringe benefits. Contact J. A. Chase, M.D., 1635 Broadway, Fort Wayne. Phone collect 219-743-7431, ext. 3651.

**OFFICE SPACE** for lease, 696 sq. ft. 3500 Lafayette Road, Indianapolis. Available immediately. Reply Box 388, The Journal, ISMA, 3935 N. Meridian St., Indianapolis 46208.

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Reception room, 3 treatment rooms, rest room. Steam heat and water furnished. \$150.00 per month. Paneled, drop ceilings, and Kentile floor. Location: 1356 West 21st Street, Indianapolis.

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## NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be consid-

ered for display type advertising.

Charges for commercial announcements are:

First four lines: \$3.00  
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Send cash with order. Average count: seven words to the line.

**DEADLINE:** Fifth day of month  
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### Indiana Medical Foundation, Inc.

Established by the Indiana State Medical Association for educational and scientific purposes, including an endowment fund for publication of **The Journal**.

Contributions made to the Foundation are deductible by donors in accordance with the Internal Revenue Code.

Bequests, legacies, devises, transfers or gifts to the Foundation are deductible for Federal estate and gift tax purposes.

The Foundation is an ideal recipient of gifts made in memory of deceased friends and relatives. A special Memorial Book is maintained to record such gifts. Special memorial funds may be established within the Foundation to honor individuals.

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August 1973

Vol. 66

• No. 8

• Indianapolis, Indiana

# The



# JOURNAL

OF THE INDIANA STATE  
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Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect.

*Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.

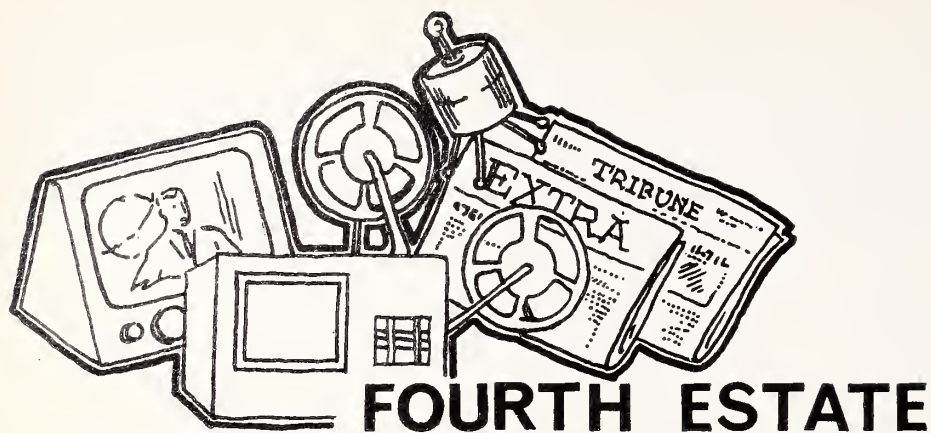


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To help you manage excessive psychic tension





This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

## Turnabout For Medication

A United States Supreme Court decision has confirmed authority of the Food and Drug Administration to move on a broad, industry-wide basis to remove from the market prescription medicines claimed to be ineffective. The law empowering it to do so was enacted in 1962.

The court also included an advisory opinion validating the FDA's move toward a similar sweeping drive to remove over-the-counter medicines it finds to be ineffective, unsafe or misbranded.

The decision may appear to be a resounding victory for the people—for their protection against the prescribing or marketing of ineffective or unsafe medicines. But much depends on how the FDA uses this broad authority.

The FDA can now proceed with an already devised four-year timetable for action against "ineffective" prescription medicines. First step is a requirement that manufacturers provide within two years, substantial evidence of effectiveness for thousands of prescription products marketed over the last 25 years. Just what is substantial evidence of effectiveness?

Suppose a patient is given a specific medicine for a specific ailment, from which he subsequently recovers. Is that evidence enough, or must it be proved that the medicine made him well? In some cases a

doctor prescribes medicine and then keeps track of the patient's progress. But in a great many others, involving simpler ailments, the doctor gives a prescription and then does not expect to see the patient again if the ailment disappears. If the patient is not heard from again about that ailment, is that evidence that the medicine was effective?

One of the FDA's targets is the combination medicine, one that includes two or more drugs. Such combinations are commonly used in treatment of colds, flu, and high blood pressure, for example. The FDA has taken the tack that a combination medicine is not "effective," and hence not marketable, if its effect is no more than the total effect of its ingredients if taken separately.

That's like banning soup on the ground that it is no more nutritious than the sum of its ingredients if eaten separately.

Some drugs do gain in effectiveness when used in combination. In other cases two or more drugs are all indicated for treatment of a particular ailment and they are combined for convenience—of the patient as well as of the doctor and pharmacist. Will the FDA ban such convenience?

We can see little dispute about removing truly ineffective medicines from the market. But it occurs to us that the best judge of the effec-

tiveness of a medicine is the patient, and the expert in closest touch with the patient is the doctor. We should think that ineffective medicines would disappear from the market because doctors would not prescribe them.

It seems to us absurd for the government to be questioning the effectiveness of prescription medicines that have been on the market for up to 25 years. Doesn't the fact that a medicine survives on the market show rather conclusively that it's effective?

But we fear the FDA will set out on a campaign to show "results" of its diligence by taking a lot of medicines off the market. In doing so it may well set standards of effectiveness that take little or no account of what patient and doctor think. And that, it seems obvious, is what should count. — *The Indianapolis Star*, June 28, 1973.

## Welcome New Service

At least half the people in Johnson county can now call the Indiana State Medical Association for free and factual medical information.

TEL-MED, as it is called, is available to those area residents who regularly call Indianapolis toll-free.

With the new electronic system, more than 100 tape recordings are available on every subject from fever to pregnancy. Simply telephone



between 8:30 a.m. and 4:30 p.m. Monday through Friday and ask for the specific subject.

The number to call is 924-6301.

The new service as announced through the news media last week, including *The Daily Journal*, seems to be very effective. The tapes run three to five minutes and are prepared and updated by physicians in central Indiana.

We feel the more the public is informed, the better they can deal with medical problems. The Indiana State Medical Association is to be credited for promoting this concept.

Try it sometime.—*Franklin Daily Journal*, Mar. 28, 1973.

## A Doctor For The Poor

At a time when medical costs are staggering and physicians are accused of growing impersonal and materialistic, the story of the retirement pastime of one doctor is heart-warming and unusual.

Dr. Eugene Balthazar, 70, continues to treat patients, but instead of billing them he is paying about \$1,000 a month out of his own pocket for the privilege.

That is the cost of operating his free clinic at Aurora, Ill., where he sees up to 85 patients a day. He dispenses drugs, bandages and shots without charge and pays the salary of a full-time nurse.

The patients drop in without an appointment.

Said Dr. Balthazar, "About 75% are acutely ill with respiration disease, infection or diarrhea. The rest

are children who need shots or school health exams."

He has the help of four volunteer nurses. He refuses donations from charitable organizations, but did agree to rent the former furniture store in which he practices from the city of Aurora for \$1 a year.

Dr. Balthazar's clinic accepts only patients who cannot afford to pay. This means that many of the doctor's former patients have to be turned away. Some of them had been with him through many of the 46 years in which he remained in private practice.

Other aspects of Dr. Balthazar's practice are unusual. He does not accept Medicaid or Medicare payments, and he is on call 24 hours a day.

Though some may say Dr. Balthazar is paternalistic, we believe he is showing a type of humanitarianism that has become too rare.

Doctors have a right to proper fees. Nevertheless, altruistic endeavors always will be refreshing.—*Bedford Times-Mail*, April 30, 1973.

## More Doctors

The General Assembly certainly receives plenty of criticism for its actions. It is a pleasure, therefore, to point out one of its noteworthy accomplishments.

The state now has 500 more physicians than it had five years ago, thanks to the funding of a new state-wide system of medical education by the 1967 General Assembly. This is an average of five and

a half more physicians per county without the heavy capital expenditures that a new medical school would have required.

Credit for this achievement also should be shared by Dr. Glenn W. Irwin, Jr., dean of the Indiana-Purdue University School of Medicine, and Dr. George Lukemeyer, executive associate dean, who conceived the plan. The state now offers the first year of medical school in all of the larger colleges and the fourth year clinical elective courses in all of the larger hospitals.

This not only makes the medical school more truly a STATE school, but it also gives medical students a more realistic view of how medicine is practiced than they were getting in the specialized hospital setting at Indianapolis.

When the program began five years ago there were 98 physicians for every 100,000 people in the state. Now there are 105.

The new system is keeping more interns and residents in Indiana, and this is especially significant because most doctors settle wherever they complete their medical education. Five years ago there were only 429 interns and residents in Indiana. This year there are approximately 600, an increase of 64 percent since the program began.

The General Assembly not only has gone a long way toward solving the doctor shortage, but it has done it in the most economical way possible. For that, Hoosiers should be grateful.—*Logansport Pharos-Tribune & Press*, May 27, 1973.

## INDIANA MEDICAL BUREAU

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### EDITORIAL AND ADVERTISING INFORMATION

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Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Communications dealing with editorial matter should be sent to Frank B. Romsey, M.D., Editor, 3266 N. Meridian St., Room 705, Indianapolis 46208. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.

Advertising rates will be furnished on request. Copy must be received by the 1st of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

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Indexed in Hospital Literature Index.





The diabetic  
who has  
too much...  
too much sugar,  
too much fat.

Maybe the last thing she needs is more of her own insulin. Especially when you consider that many overweight diabetics already have normal or high levels of endogenous insulin and that insulin is lipogenic.

If she just won't diet and oral therapy is indicated in adult-onset, nonketotic diabetes...

**DBI-TD® Geigy**  
phenformin HCl

lowers blood sugar without raising blood insulin.

For complete details, including dosage, please read the prescribing information. It's summarized below.

**DBI® phenformin HCl**  
Tablets of 25 mg.  
**DBI-TD® phenformin HCl**  
Timed-Disintegration  
Capsules of 50 and 100 mg.

**Indications:** Stable adult diabetes mellitus; sulfonylurea failures, primary and secondary; adjunct to insulin therapy of unstable diabetes mellitus.

**Contraindications:** Diabetes mellitus that can be regulated by diet alone; juvenile diabetes mellitus that is uncomplicated and well regulated on insulin; acute complications of diabetes mellitus (metabolic acidosis, coma, infection, gangrene); during or immediately after surgery where insulin is indispensable; severe hepatic disease; renal disease with uremia; cardiovascular collapse (shock); after disease states associated with hypoxemia.

**Warnings:** Use during pregnancy is to be avoided.

**Precautions:** 1. *Starvation Ketosis:* This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria which, in spite of rel-

atively normal blood and urine sugar, may result from excessive phenformin therapy, excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state. **Do not give insulin without first checking blood and urine sugar.**

2. *Lactic Acidosis:* This drug is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, periodic determinations of ketones in the blood and urine should be made in diabetics previously stabilized on phenformin, or phenformin and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH, and the lactate-pyruvate ratio. The drug should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis.

3. *Hypoglycemia:* Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.

**Adverse Reactions:** Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake. (B) 98-146-103-E (6/72)

For complete details, including dosage, please see full prescribing information.

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# "Prescription drugs – who should determine the maker?"

## Dispenser of Medicine

Clifton J. Latiolais  
President  
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Association



## Maker of Medicine

C. Joseph Stetler  
President  
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Manufacturers  
Association



"Too many doctors are indifferent to the economic consequences of their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by former AMA Chief Executive F. J. L. Blasingame, M.D.

### Doctor, are you indifferent...?

In discussing an anticipated increase in Blue Shield rates, Dr. Blasingame's newsletter had this to say:

"In general, it can be said, MD's have given the impression they are not particularly concerned with the increase in cost of health care to their patients...

"True, an MD's training is primarily scientific, but in the real world of practice, all of his scientific decisions have a price tag, or an economic impact. The economics of health care beckon the practitioner's attention. Concern for economics of medicine

When the pharmacist recommends that a drug product other than the one ordered be dispensed, the prescriber invariably permits the change when he feels the best interests of the patient will be served.

### Shortcomings of Pro-Substitution Argument

The fact remains that it is necessary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, the unilateral decision of the pharmacist, made in the absence of clinical knowledge of the patient, could expose him to needless risks, and in addition, jeopardize the relationship between the professions of Pharmacy and Medicine. In my view, there is nothing in the pro-substitution argument that offsets these risks.

### The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowledge about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degree puts him at a disadvantage. Most often, a practicing physician will need expert knowledge of no more than 25



should be an obligation of medical practice...

"Medical societies ought to conduct continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in the patients' interest, question the tactics of any insurance organization that raises health care costs by forcing policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed to their patients for support in the fight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

Cost of Drugs

Insurance rates and hospital charges are only two factors in health

care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists are concerned. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much misinformation has been purposely spread by those who stand to gain financially by maintaining

high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

AphA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

or 30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with the particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substituting pharmacist may avoid even a technical breach of contract by simply notifying the patient that he is making the substitution. I would judge that few courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could follow legalization of substitution. We have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests

the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock all brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advo-

cates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

Pharmaceutical  
Manufacturers Association  
1155 Fifteenth Street, N.W.  
Washington, D.C. 20005



# THE INDIANA STATE MEDICAL ASSOCIATION

3935 N. Meridian, Indianapolis 46208—Telephone 925-7545  
ANNUAL CONVENTION—OCTOBER 6-11, 1973—Indianapolis

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Treasurer—Hugh K. Thatcher, Jr., 4548 College Ave., Indianapolis 46205.

Assistant Treasurer—Arvine G. Popplewell, 960 Locke St., Indianapolis 46202  
Chairman of Executive Committee—Donald M. Kerr, 2900 W. 16th St., Bedford 47421  
Executive Secretary—Mr. James A. Waggener, 3935 N. Meridian, Indianapolis 46208.

## TRUSTEES

District	Term Expires
1—Gilbert M. Wilhelmus, Evansville (Chairman)	Oct. 1974
2—Paul W. Holtzman, Bloomington	Oct. 1975
3—Eli Goodman, Charleslawn	Oct. 1973
4—Howard C. Jackson, Madison	Oct. 1974
5—Cleon M. Schauwecker, Greencastle	Oct. 1975
6—Paul M. Inlow, Shelbyville	Oct. 1973
7—John O. Butler, Indianapolis	Oct. 1974
7—Joseph F. Ferrara, Franklin	Oct. 1975
8—Richard Ingram, Montpelier	Oct. 1975
9—William M. Sholty, Lafayette	Oct. 1973
10—Vincent J. Santare, Munster	Oct. 1974
11—James A. Harshman, Kokomo	Oct. 1975
12—William R. Clark, Fort Wayne	Oct. 1973
13—G. Beach Gattman, Elkhart	Oct. 1974

## ALTERNATES

District	Term Expires
1—Raymond Newnum, Evansville	1973
2—Betty Dukes, Dugger	1974
3—Thomas Neathamer, Jeffersonville	1974
4—William Blaisdell, Seymour	1973
5—William G. Bannon, Terre Haute	1973
6—Glen Ward Lee, Richmond	1975
7—John Pantzer, Indianapolis	1975
7—Donald McCallum, Indianapolis	1974
8—Jack L. Alexander, Muncie	1973
9—Max N. Haffman, Cavington	1974
10—Martin O'Neill, Valparaiso	1975
11—Lloyd L. Hill, Peru	1974
12—Walter D. Griest, Fort Wayne	1974
13—Donald S. Chamberlain, South Bend	1973

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Chairman—Malcolm L. Wrege, Indianapolis  
Vice-chairman—J. Robert Edwards, Auburn  
Secretary—Lowell Hillis, Logansport

### Section on Internal Medicine:

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Vice-chairman—John L. Ferry, Hammond  
Secretary—Chas. W. Magnuson, South Bend

### Section on Family Physicians

Chairman—James T. Anderson, Greenfield  
Vice-chairman—James R. Daggy, Richmond  
Secretary—David M. Hadley, Plainfield

### Section on Obstetrics and Gynecology:

Chairman—Jerome F. Doss, Kokomo  
Vice-chairman—David E. Copher, Indianapolis  
Secretary—Charles R. Thomas, Indianapolis

### Section on Ophthalmology and Otolaryngology:

Chairman—Kenneth Isenogle, Fort Wayne  
Vice-chairman—Wallace Dyer, Evansville  
Secretary—David Kenney, Indianapolis

### Section on Anesthesiology:

Chairman—Willis W. Stogsdill, Indianapolis  
Secretary—David P. Lehman, Kokomo

### Section on Public Health and Preventive Medicine:

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Vice-chairman—Robert M. Seibel, Nashville  
Secretary—David Edwards, Indianapolis

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Chairman—Dale B. Parshall, Elkhart  
Vice-chairman—James G. Lorman, Fort Wayne  
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Vice-Chairman—Wallace R. Van den Bosch, Lafayette  
Secretary—Richard N. French, Jr., Indianapolis

### Section on Pathology and Forensic Medicine:

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President-elect—Wei-Ping Lah, Gary  
Secretary—Victor Muller, Indianapolis

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Secretary—Robert M. Sweeney, South Bend

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Secretary—W. Thomas Spain, Evansville

### Section on Cutaneous Medicine:

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Vice-chairman—Howard R. Gray, Indianapolis  
Secretary—Victor G. Hackney, Indianapolis

### Section on College Health Physicians:

Chairman—John Miller, Bloomington  
Secretary—Wayne G. Pippenger, Muncie

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Terms expire December 31, 1973:

Delegates	Alternates
Jack E. Shields Brownstown	Patrick J. V. Carcaran Evansville
Lowell H. Steen Hammond	Thomas C. Tyrrell Hammond

Terms expire December 31, 1974:

Delegates	Alternates
James A. Harshman Kokomo	A. Alan Fischer Indianapolis
Eugene F. Senseny Fort Wayne	Ross L. Egger Daleville
Malcolm O. Scamahorn Pittsboro	Kenneth O. Neumann Lafayette

## 1972-73 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1.	William Dye, Oakland City	Martin J. Bender, Evansville	
2.		J. S. Brown, Carlisle	
3.	Claude J. Meyer, Jeffersonville	Robert K. McKechnie, Jeffersonville	September 26, 1973, Clarksville
4.	Joe M. Black, Seymour	John W. Ripley, Seymour	Seymour
5.	J. Franklin Swain, Rockville	Antolin M. Mantecillo, Clinton	
6.	James H. Tower, Jr., Shelbyville	Arlington M. Hudson, Connersville	Cannerville
7.	Eric Clark, Plainfield	M. O. Scamahorn, Pittsboro	
8.	David Dietz, Muncie	Arthur Jay, Muncie	Aug. 29, 1973, Muncie
9.	Milton W. Erdel, Frankfort	Harry T. Staut, Frankfort	June 13, 1974, Frankfort
10.	Lambro Dimitroff, Hammond	Mario D. Mansueto, Munster	Sept. 5, 1973, Valparaiso
11.	Joseph S. Bean, Logansport	Fred Paehler, La Fontaine	Oct. 3, 1973, Marion
12.	George C. Manning, Fort Wayne	William B. Hughes, Waterloo	Sept. 13, 1973, Fort Wayne
13.	James Rimel, Plymouth	David L. Spalding, Mishawaka	Sept. 12, 1973, Plymouth





This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to The Journal on the first of each month preceding month of issue.

### **Interim Regulations Issued**

The HEW Department issued interim regulations to guide the new chronic kidney disease treatment benefit program which, it estimated, will cost \$250 million in the first year and could rise to \$1 billion a year in five years. The expansion of Medicare to cover costs of kidney dialysis and transplants for beneficiaries of all ages started July 1. Under interim rules, the number of facilities providing dialysis and transplants has been frozen at those now operating. The regulations also freeze reimbursement to a level of cost or charge representing an average of the charges during the previous year. Reimbursement for maintenance dialysis is limited to a "ceiling" set by the department (\$150 per dialysis), above which a justification would be required. All facilities must agree to the assignment method of reimbursement. Final regulations are due by the first of the year.

### **PSRO Author to Retire from Senate**

Sen. Wallace F. Bennett, ranking Republican on the Senate Finance Committee, won't run for re-election next year. The 74-year-old Republican from Utah has served four terms in the Senate. Replacing Bennett as top Republican on the powerful Finance Committee will be Sen. Carl Curtis (R., Nebr.). Bennett, one of the Senate's most influential conservatives, is author of the controversial Professional Standards Review Organization (PSRO) amendment to the Medicare-Medicaid bill of last year. He cited his age as a factor in his decision. "I can't deny the calendar." A few days earlier, Sen. Norris Cotton (R., N.H.) had announced he will not run again.

### **California Surgeon Named President-Elect of AMA**

Malcolm C. Todd, M.D., a Long Beach, Calif., general surgeon, is the new president-elect of the American Medical Association. He was elected by the House of Delegates during AMA's annual convention.

The 60-year-old Dr. Todd will serve one year and take office as the Association's 129th president next June in Chicago.

Dr. Todd was born April 10, 1913 in Carlyle, Ill. He is a graduate of the University of Illinois and Northwestern University Medical School.

An associate clinical professor of surgery at the University of California in Irvine, Dr. Todd is a Fellow of the American College of Surgeons, International College of Surgeons, American College of Gastroenterology, and a diplomate of the American Board of Surgery.

Dr. Todd is a past president of the California Medical Association and has been a member of AMA's House of Delegates since 1959. He is chairman emeritus of AMA's Council on Health Manpower and a member of the National Advisory Committee on Health Manpower.

Dr. Todd is married to the former Ruth Holle Schlake of Chicago. They have one son, Malcolm Douglas Todd.

### **Major PHS Programs Get One-Year Extension**

President Nixon cited "a spirit of partnership" with Congress as he signed a one-year extension of major Public Health Service programs. The extension had been strongly opposed by the Administration, which wanted to eliminate 5 of the 12 programs and cut others.

The Chief Executive declared that the bill strikes "a reasonable compromise with the Administration," noting that it keeps the programs alive for only one year instead of the customary three. In adopting the bill by overwhelming votes, Congress expressed an intention to review the programs to determine if it agreed with the Administration's policy decisions.

The 12 programs involved and the money authorizations for the fiscal year that started July 1 are:

*Continued*



# COUNTY MEDICAL SOCIETY DIRECTORY

## County

Adams  
Allen (Fort Wayne)

Bartholomew-Brown  
Benton  
Boone  
Carroll  
Cass  
Clark  
Clay  
Clinton  
Davless-Martin  
Dearborn-Ohio  
Decatur  
DeKalb  
Delaware-Blockford  
Dubois  
Elkhart  
Fayette-Franklin  
Floyd  
Fountain-Warren  
Fulton  
Gibson  
Grant  
Greene  
Hamilton  
Hancock  
Harrison-  
Crawford  
Hendricks  
Henry  
Howard  
Huntington  
Jackson-Jennings  
Jasper  
Jay  
Jefferson-Switzerland  
Johnson  
Knox  
Kosciusko  
LaGrange  
Lake

LaPorte

Lawrence  
Madison  
Marion

Marshall  
Miami  
Montgomery  
Morgan  
Newton  
Noble  
Orange  
Owen-Monroe  
Porke-Vermillion  
Perry  
Pike  
Porter  
Posey  
Pulaski  
Putnam  
Randolph  
Ripley  
Rush  
St. Joseph

Scott  
Shelby  
Spencer  
Starke  
Steuben  
Sullivan  
Tippecanoe  
Tipton  
Vanderburgh  
Vigo

Wabash  
Warrick  
Washington  
Wayne-Union  
Wells  
White  
Whitley

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A. L. Coddens, Earl Park  
Kathryn Jackson, Zionsville  
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Max E. Pfuetze, Logansport  
Thomas J. Corrao, Jeffersonville  
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Eric Clark, Plainfield  
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Robert Inlow, Shelbyville  
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William L. Daugherty, Hutsonville, Ill.  
Robert E. Hannemann, Lafayette  
Albert E. Stouder, Kempton  
L. Ray Stewart, Evansville  
Edward M. Johnson, Terre Haute

Marvin Dziabis, North Manchester  
Peter B. Hoover, Boonville  
F. T. Castueras, Salem  
Tom H. Ebbinghouse, Richmond  
Louis F. Bradley, Bluffton  
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John Wilson, Columbia City

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Kingdon Brady, Jasper Co. Hospital, Rensselaer 47978  
Amin T. Nasr, Jay County Hospital, Portland  
Ott B. McAtee, Madison State Hospital, Madison  
Paul Reynolds, 1035 W. Jefferson St., Franklin 46131  
Rudsen M. Bueser, 410 South 7th St., Vincennes 47591  
Roland Snider, 604 E. Winona, Warsaw 46580  
Allen S. Martin, Shipshewana 46565  
R. J. Bills, 504 Broadway, Gary 46402  
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William L. Purcell, Exec. Secy., P. O. Box 986, Terre Haute  
Wilbur McFadden, 1104 N. Wayne St., North Manchester 46962  
Robert C. Colvin, Newburgh  
V. J. Tadatada, 103 E. Market St., Salem 47167  
John Dehner, Reid Memorial Hospital, Richmond  
Russell E. Graf, 1110 Highland Park Circle, Bluffton 46714  
W. Martin Dickerson, 1114 O'Connor Blvd., Monticello 47960  
James R. Roth, 323 N. Chauncey, Columbia City 46725



# MONTH IN WASHINGTON

Health services research and demonstration (\$42.6 million); National health statistics (\$14.5 million); Public health training (\$23.3 million); Migrant health services (\$26.7 million); Comprehensive health planning (\$360.5 million); Medical libraries (\$8.4 million); Hospital construction (\$197.2 million); Allied health training (\$44.3 million); Regional medical programs (\$159 million); Family planning (\$118 million); Community mental health centers (\$234 million); Developmental disabilities (\$41.7 million).

The Administration had urged Congress to eliminate or phase out the hospital construction or Hill-Burton program, public health training, allied health training, regional medical program (RMP) and community mental health centers.

The RMP program has already been disbanded at HEW headquarters. Apparently, some sort of a make-shift arrangement will have to be set up to keep it operating for one more year.

There was only one vote in Congress—by Rep. Philip Crane (R. Ill.)—against the extension bill, which made unlikely any successful veto.

The chief Administration argument for closing down the five programs was that they were inefficient, had outlived their usefulness, or could be handled more appropriately by the states.

## Eleven Appointed to PSRO Council

The important national Professional Standards Review council has been established with the appointment of 11 physicians. The council will advise HEW Secretary Caspar Weinberger on the Professional Standards Review Organizations (PSRO) program to monitor the quality of medical care in Medicare and Medicaid.

“The contribution of this council will be vital to the accomplishment of the objectives of the PSRO legislation, and we are indeed fortunate to be able to draw upon such a high caliber of expertise,” Weinberger said.

Members of the council were selected from among 200 physicians of recognized standing and distinction in the appraisal of medical practice who were nominated by national organizations representing practicing physicians and by consumer groups and other health care interests.

Those appointed to serve a three-year term on the council are:

**Brown, Clement R., M.D.**, director of medical education, Mercy Hospital and Medical Center, Chicago; **Covell, Ruth M., M.D.**, assistant to dean of

School of Medicine, University of California at San Diego; **Duval, Merlin K., M.D.**, vice president for health sciences, University of Arizona, former assistant HEW secretary for Health; **Greene, Thomas J., M.D.**, surgeon, Detroit; **Haggerty, Robert J., M.D.**, Professor of Pediatrics, University of Rochester, N.Y., School of Medicine and Dentistry; **Harrington, Donald C., M.D.**, Obstetrician-gynecologist and medical director, San Joaquin Foundation for Medical Care, Stockton, Calif.; **Hunter, Robert B., M.D.**, family physician, Sedro Woolley, Wash., member of the board of the American Medical Association; **Nelson, Alan R., M.D.**, internist, Salt Lake City, Utah, alternate delegate to AMA; **Saloom, Raymond J., D.O.**, Osteopathic physician, Harrisville, Pa.; **Saward, Ernest W., M.D.**, Professor of Social Medicine, University of Rochester School of Medicine and Dentistry, Rochester, N.Y.; **Scrivner, Willard C., M.D.**, obstetrician-gynecologist, Belleville, Ill., president of the Illinois State Medical Society and member of AMA committee on health care of the poor.

## Dr. Robert Moser Named JAMA Editor

The Board of Trustees has appointed Robert H. Moser, M.D., chief editor of the *Journal of the American Medical Association*, effective October 1. At the same time Dr. Moser will become director of the Division of Scientific Publications, which has editorial responsibility for *JAMA* and the AMA's 10 specialty journals.

Hugh H. Hussey, M.D., who has held both positions since 1970, will remain a fulltime member of the staff as editor emeritus. He will also assume responsibilities for coordinating publication of the specialty journals.

A graduate of the Georgetown University School of Medicine, Dr. Moser, 50, currently practices internal medicine with the Maui Medical Group, Wailuku, Hawaii. Certified by the Board of Internal Medicine, Dr. Moser followed a career of medical officer in the U.S. Army, rising to the position of chief of medicine at Walter Reed General Hospital, Washington, D.C. He had an appointment to the clinical faculty at Georgetown, where he was active in teaching, research and the authorship of a number of original articles. Currently he is clinical professor of medicine at the University of Hawaii and the University of Washington Colleges of Medicine.

With a background that includes teaching but emphasizes the day-to-day problems that confront an in-



# ISMA Committees and Commissions for 1972-1973

## COMMITTEES

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Donald M. Kerr, Bedford, chairman; Vincent J. Santare, Munster; James H. Gosman, Indianapolis, president; Joe Dukes, Dugger, president-elect; Gilbert M. Wilhelmus, Evansville, chairman of the Board of Trustees; Hugh K. Thatcher, Jr., Indianapolis, treasurer; Arvine G. Poppellwell, Indianapolis, assistant treasurer.

### Grievance

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### Future Planning

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ternist in private practice, Dr. Moser has a deep appreciation of the practical requirements a medical journal must meet. He has impressed the Board with his dedicated resolve both to continue *JAMA*'s high standards of scientific excellence and, at the same time, to rededicate its purpose to serving the needs of the office-based practitioner.

**Says Drug Abuse By Young Athletes  
Probably Increasing**

The special use of drugs by young athletes is probably increasing in the same proportion as drug abuse is increasing among the general student population, the American Medical Association has told a Senate subcommittee.

Dr. Donald L. Cooper, team physician at Oklahoma State University and a member of an AMA committee concerned with the medical aspects of sports, noted before a subcommittee investigating juvenile delinquency that while there are no current surveys on drug abuse by young athletes, earlier studies show a direct correlation of use by athletes and the general student body.

The report of the National Commission on Marijuana and Drug Abuse, Dr. Cooper pointed out, "indicates that drug abuse among the general student population has increased, and it is logical to expect that athletes as members of that subculture have also been influenced to abuse drugs more in recent years."

Emphasizing AMA's longtime stand that drugs and athletics don't mix, Dr. Cooper said that in his opinion drugs—amphetamines—do not enhance athletic performance, despite some conflicting reports in the literature as to possible minimal benefits.

"Some studies actually show impairment of certain skills," Dr. Cooper said, warning that there can also be substantial detrimental effects from continued amphetamine abuse.

Dr. Cooper pointed out that concerted efforts have been made by the athletic community to control abuse despite the incentive to use any method to improve performance, particularly in international competition.

However, Dr. Cooper cautioned against mass testing programs, such as the monitoring of urine, saying such programs throughout the nation for school and college athletes would be scientifically unreliable, expensive and time consuming.

**Delay Urged on Cough and Allergy Prescription  
Products Guidelines**

Spokesmen for drug companies and physicians' groups have urged the Food and Drug Administration

to delay guidelines on what cough and allergy prescription products may contain.

"These products have been used safely and successfully by physicians for decades," the American Medical Association told a FDA hearing. Asking no "precipitous action," the AMA said "there is hardly a citizen who has not received some relief from bothersome symptoms via one or more of these products."

The proposed guidelines cover more than 200 of the most widely prescribed prescription cough and allergy medicines. Specific limitations would be placed on composition such as banning combinations of expectorants and antihistamines. Effect will be to bar continued marketing of many cough and allergy preparations.

John H. Budd, M.D., a member of the AMA Board of Trustees, said the interim guidelines would not serve the public interest. Dr. Budd noted that a FDA panel on over-the-counter drugs is reviewing the OTC situation. "It is apparent that the final monograph that emerges from this review process will have a substantial bearing on the formulation and labeling of prescription as well as OTC drugs . . . and in many respects will determine the related issues," said Dr. Budd.

The proposed interim guidelines were not formulated under the specific requirements of the drug law, he said, "but rather were devised on the basis of subjective judgments made by members of the appropriate drug efficacy study panels."

The AMA official said that if one considers the contribution any one drug may make to a mixture, published evidence as specified in the law does not exist for any of the classes of drugs in cough mixtures: antitussives, expectorants, antihistamines, decongestants, demulcents or flavorings.

"The problem that confronts us is not a simple straightforward one such as determining the effect a drug has on bacterial multiplication, urine output or level of a plasma constituent. Rather we are in the difficult area of subjective human feelings, symptoms with profound psychological as well as physical parameters. The remedies for cough were developed by trial and error over decades and even hundreds of years. The long history behind the expectorant ingredients . . . have put them, in the doses used, to the test of safety and by the impressions of clinicians to the test of effectiveness. How effective they are is difficult to measure since, for coughs, the placebo effect is extremely important. Many coughs respond simply to a drink of water. Other coughs respond to expectorants. Still others respond only to substantial doses of codeine or an equivalent antitussive, and finally some coughs will yield to nothing yet devised."





## The value of early fitting

Research has proven the fitting of prostheses on children should be accomplished as early as is practicable. It has only been a few years since the child amputee was not considered ready until just before pre-school age or even later. Extensive experience demonstrates that fitting at a much earlier age produces more effective results.

If there are no complicating factors, children with arm amputations usually should be provided with a passive type of prosthesis soon after they are able to sit alone, generally at about six months of age. Lower-extremity child amputees should be fitted with prostheses as soon as they show signs of wanting to stand. The development of muscular coordination of child amputees is the same as for non-handicapped children; and, therefore, this phase may take place as early as eight months or as late as 20 or more months.

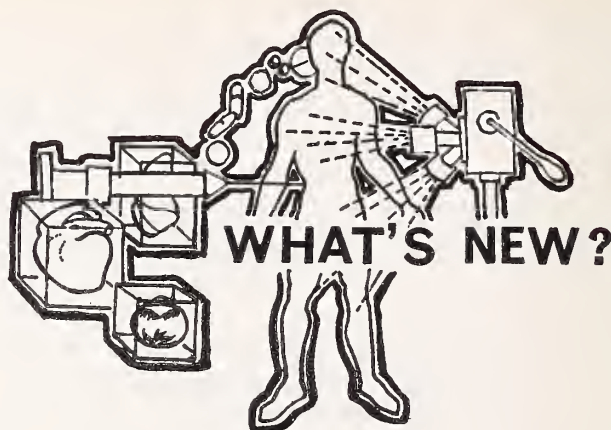
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"The bus driver paid his bill today."



\* \* \*

The 3M Company announces improved strength and adhesion in the new reinforced Steri-Strip brand skin closure. The closures are packaged sterile in a double-sealed, peel-open polyethylene envelope. The envelopes are packed 50 to a box.

\* \* \*

Endo Laboratories has begun marketing REMSED (promethazine hydrochloride), for the production of light sleep from which the patient can be easily aroused when necessary. It is suitable for use in pediatric and geriatric patients as well as in the usual adult patients.

\* \* \*

Posey introduces a safety strap designed to fit the Lazy "D" Chair. Special wire clamps make it possible to place the strap on the chair back at any height which is convenient. The two pieces are held together in front of the chair occupant by Velcro closure.

\* \* \*

Elcor, Products by Welex Electronics, has published an engineering bulletin that describes how a new series of isolation transformers reduces the "micro-shock" hazard as well as the possibility of primary-to-secondary shorts in medical/hospital setups. The bulletin, which is designated 194-1272, discusses OPTION "H" Power Isoformers.®

\* \* \*

Doubleday has just published "We Mainline Dreams," The Odyssey House Story, by Judianne Densen-Gerber, an M.D. and a lawyer, who is executive director of Odyssey House and who has devised what is called the nation's most effective rehabilitation program for addicts. \$9.95.

\* \* \*

Lakeside is introducing a new automatic wheel chair which they call "Freedom Machine." It has an entirely new design concept. Its wheels are within the frame-work and do not interfere with furniture. It is powered by a 12-volt auto battery which recharges from any standard electric outlet. The back folds down for easy transportation by automobile.

\* \* \*

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.





## Placidyl® (ETHCHLORVYNOL)

### Brief Summary

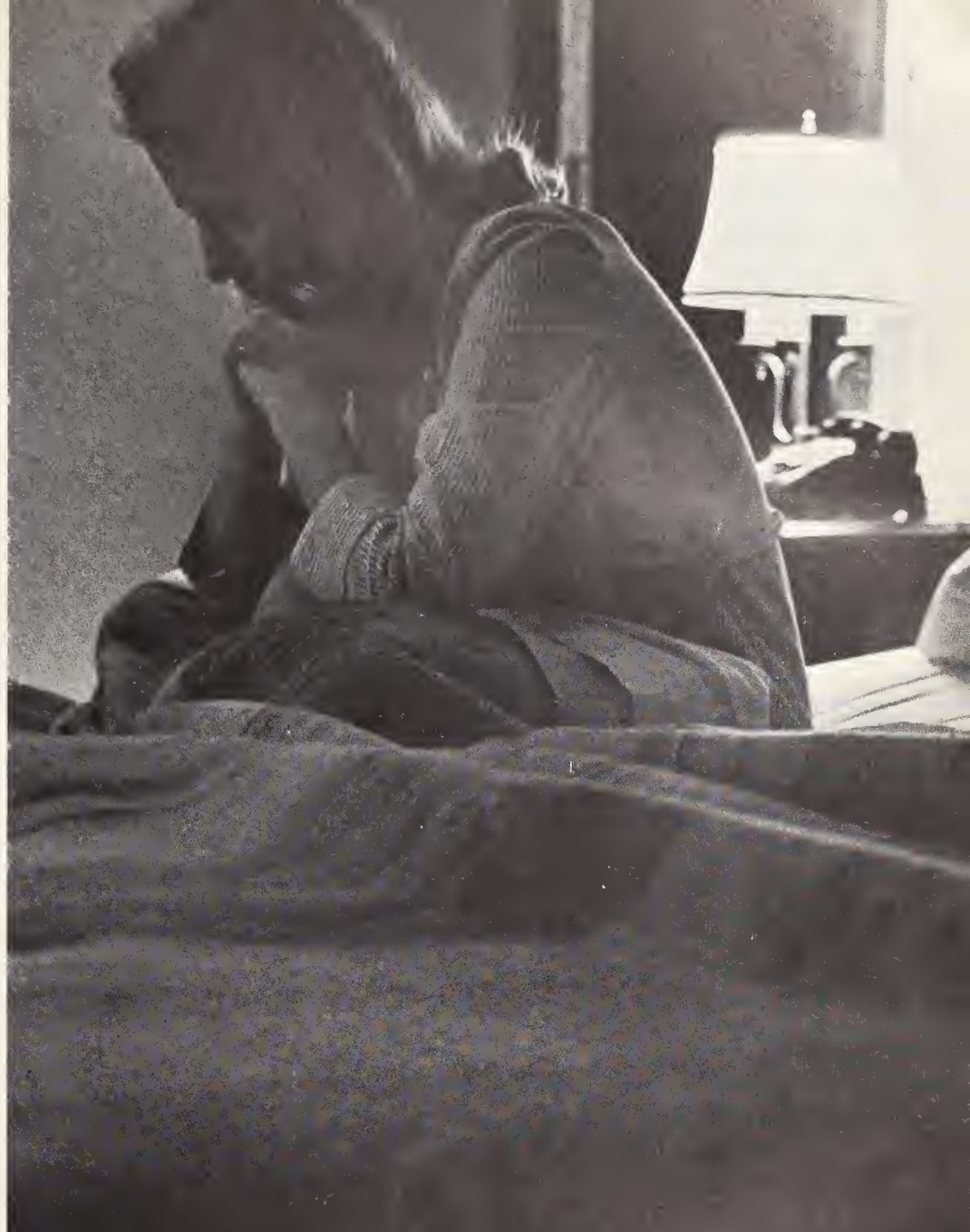
**Indications**—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

**Contraindications**—Drug hypersensitivity and porphyria.

**Warnings**—Not recommended during the first and second trimester of pregnancy. Caution patients with possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. Administer with caution to patients with suicidal tendencies and do not prescribe large quantities of the drug. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction—One patient or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

**Precautions**—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited in elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitriptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients may respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, syncope without marked hypotension. Transient dizziness or ataxia may occur.

**Adverse Reactions**—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction manifested by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 302430R



## Give us her nights.

Prescribe Placidyl. Chances are, we'll give her a good night's sleep.

Insomnia is often associated with emotional disturbance. Emotional problems might be the cause . . . or the effect. In time that can be determined. But tonight, one fact is painfully clear: she needs sleep.

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(ETHCHLORVYNOL CAPSULES, 500 or 750 mg.)





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**INDICATIONS:** *Therapeutically*, used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in:

- infected burns, skin grafts, surgical incisions, otitis externa
- primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia)
- secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis)
- traumatic lesions, inflamed or suppurating as a result of bacterial infection.

*Prophylactically*, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

**CONTRAINDICATIONS:** Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

**PRECAUTION:** As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

## NEOSPORIN<sup>®</sup> Ointment

(POLYMYXIN B-BACITRACIN-NEOMYCIN)

Each gram contains: Aerosporin<sup>®</sup> brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q.s. In tubes of 1 oz. and ½ oz. and ¼ oz. (approx.) foil packets.



Wellcome

Burroughs Wellcome Co.  
Research Triangle Park  
North Carolina 27709



## Complete Product Information:

**Description:** Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is *N*-(5-methyl-3-isoxazolyl)sulfanilamide. It is an almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

**Actions: Microbiology:** Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with *para*-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

*In vitro* studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

*In vitro* serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa*. The following organisms are usually susceptible: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis* and indole-positive proteus species.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms (MIC—mcg/ml)				
Bacteria	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20) TMP SMX	
<i>Escherichia coli</i>	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
<i>Proteus</i> spp. indole positive	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
<i>Proteus mirabilis</i>	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
<i>Klebsiella-Enterobacter</i>	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

**Human Pharmacology:** Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. On repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma decreases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than are the concentrations in the blood. When administered together as in Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

**Indications:** Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, and, less frequently, indole-positive proteus species).

**Important note:** Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.

**Contraindications:** Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction Studies).

**Warnings:** Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

**Precautions:** Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

**Adverse Reactions:** For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

**Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

**Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

**Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

**C.N.S. reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

**Miscellaneous reactions:** Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

**Dosage and Administration:** Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

**How Supplied:** Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

**Reproduction Studies:** In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

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This paper is a brief review of Huntington's (Chorea) Disease, its history, geographical distribution and genetic laws. The prevalence of Huntington's Disease in Indiana is pointed out. Ninety-five consecutive admissions to the Madison State Hospital from 1910-1971 are analyzed. The principal data of the study are presented in four tables.

### *Huntington's Disease in Southeastern Indiana*

OTT B. McATEE, M.D.  
Madison

HUNTINGTON'S Disease (chorea) may strike one person in 4000 throughout Indiana and one in 2500 in Southeastern Indiana, unless death overtakes this person before midlife. The diagnosis carries with it a hopeless, relentless course of social and mental deterioration, and the patient's years of lingering bring anxieties and fears to his offspring and other kindred.

In 1872<sup>1</sup> George Huntington of Pomeroy, Ohio, a 22-year-old physician who had migrated to Southeastern Ohio from Long Island, N.Y., was the first to describe the disease. He had learned of chorea on Long Island from his father's and grandfather's total of 77 years of medical practice. Huntington apparently encountered the disease in his practice along the Ohio River and wrote a paper in which he pointed out its hereditary nature, the tendency to insanity and suicide, and its manifesting itself as a grave disease in adult life.

Huntington's Disease has been observed throughout most of the world. It exists in Australia, China, Japan, Europe, North and South America. Concentrations of the disease are found in areas where the population tends to be isolated geographically and along routes of migration. Rosenthal<sup>2</sup> states that the world incidence varies from .33 per 100,000 in Japan, to 6.5 per 100,000 in North Hamptonshire, England.

A study completed in Michigan,<sup>3</sup> found a frequency of 4.12 cases per 100,000 population, or about one choreic per 24,300 individuals. Based on preliminary and incomplete studies, this author estimates that the incidence of Huntington's Disease throughout Indiana equals the incidence in Michigan and is noticeably higher in Southeastern Indiana.

The disease has been traced to an autosomal (non sex-linked) dominant gene.<sup>4</sup> The physician should remain aware of the genetic fact

that the disease is hereditary and is transmitted by genes in accordance with Mendel's laws of dominance. Children of a couple in which one parent carries the gene have a 50-50 chance of carrying the genes themselves. If they do not carry the gene, they will never have the disease and will not transmit it to their children. However, they cannot be sure of this until they have remained unaffected well into adulthood and childbearing period. If the individuals do not know the facts concerning the disease, they have no choice but to become acquainted with the consequences after the consequences have arisen. Eugenic counseling has been available to some relatives but up to now sparingly used. Some families use denial and will not let themselves accept the fact that there is a 50-50 chance that each descendant will develop the disease. Too often the affected partner does not reveal the facts to his or her spouse until after children are born.



This author<sup>5</sup> with Stevens<sup>6</sup> did a study of 95 consecutive cases of Huntington's Disease treated at the Madison State Hospital, Madison, Indiana, from the Hospital's opening in August 1910 through December 1971. This study was made from clinical records, personal contacts with patients and their families, and field surveys by Stevens<sup>6</sup> and others. The population of the Hospital's Southeastern Indiana district, largely rural, rose from about 500,000 to 700,000 during the 61 years of the study.

Reference to Table 1 reveals the average age of onset of the first symptoms for both sexes in 85 of the cases to be 38.9 years while the range in age at onset was 13 to 66 years. The average age on admission was 46.2 years for both sexes, while the age range for first admissions was 19 to 76 years.

The average number of years spent in the hospital before discharge or death was 5.8 years for both sexes. The range was from 18 days to 27 years. During this period of 61 years of the Hospital's service, there was a daily average of nine (9) choreic patients in residence.

The age at death of 71 cases ranged from 24 to 76 years, or an average of 53.2 years for both sexes. On reviewing the cases in light of physical characteristics it was found that 50.5% of the cases were male and 49.5% female. (See Table 2)

TABLE 2  
PHYSICAL CHARACTERISTICS

Variable	Total Cases Studied	Male (%)	Female (%)	All (%)
Sex	95	50.5	49.5	
Caucasian	95	100	100	100
Mean height (in.)	88	67	63	65
Mean weight (lb.)	88	130.5	116.1	123.3
Physical condition time of admission	90			
Vigorous		21	17	19
Ambulatory		56	64	60
Infirmary		23	19	21
Autopsies conducted	68	8.8	10.3	19.1

All cases were from the white race. On admission, the physical condition was vigorous in only 20% of the cases. Twelve autopsies completed (since 1958) in which the brain was studied by a neuropathologist showed typical neuropathological findings: (1) Cerebral cortical atrophy; (2) Internal hydrocephalus; (3) Striatal degeneration and reactive gliosis.

In 93 cases, 69.6% of the males and 100% of the females had been married. (See Table 4) Nine percent of the males and 28% of the females had a multiple number of marriages (See Table 3). Of 79 married patients, 91.4% of the males and 84% of the females had offspring, for an average of 3.7 and 3.5 children respectively.

Treatment at the Madison State

Hospital has been designed largely to provide an environment best suited to meet the symptoms of this degenerating disease. Numerous drugs, including barbiturates and tranquilizers, have been tried without favorable results in controlling the choreic movements. Electroconvulsive therapy has been used on some patients who were depressed and suicidal. Decubiti were a complication in many cases, and aspiration pneumonia often closes the picture.

It can be conservatively estimated that the State hospitals in Indiana have admitted one fourth of all clinically manifested cases during the past 60 years. Based on preliminary surveys from the State Hospitals at Richmond, Evansville, Logansport, Central and Norman

TABLE 1  
LENGTH OF HOSPITALIZATION AND AGE AT ONSET, HOSPITAL ADMISSION, AND DEATH

Variable	Total Cases Studied	Mean (years)			Median (years)			Range (years)		
		Male	Female	All	Male	Female	All	Male	Female	All
Onset age	85	39.1	38.7	38.9	37.5	36.7	37.1	(13-64) 52	(20-66) 47	(13-66) 54
Admit age	95	47.5	45.0	46.2	49.0	46.5	47.5	(19-76) 58	(24-73) 50	(19-76) 58
Years hospitalized	95	5.1	6.5	5.8	4.3	3.7	4.2	(.05-27) 26.96	(.08-25.5) 25.43	(.05-27) 26.96
Death age	71	55.3	51.1	53.2	55.5	51.5	54.3	(24-76) 53	(31-75) 45	(24-76) 53



Beatty, the Madison State Hospital has treated more Huntington's cases. This observer believes that the concentration of Huntington's Disease in Southeastern Indiana is higher than in any area that has been reported in the Midwestern States.

During the first 21 years of Madison State Hospital's history, .44% of all admissions were Huntington's disease, while during the next 40 years the rate increased to .61% and is expected to increase to more than 1% during the next 10 years. A survey made by the Nursing Service Staff at the Madison State Hospital found that the hospitalized choreic patient requires three times more hours of nursing care than do other patients in the same setting.

Stevens<sup>6</sup> in 1933 found that all choreic admissions to Madison State Hospital were coming from 12 families. The largest family in Stevens' survey has been brought up to date. There have been 970 descendants born to this family—traced through eight generations beginning approximately 180 years ago. There are approximately 400 members of this family now living who are under 40 years of age; 50% of these, or 200 people, are certain to develop the disease unless some other fatal disease intervenes. Stevens<sup>6</sup> in 1963 found that the disease had apparently disappeared from one of the smaller families.

This genetic disease is preventable once it is known to exist in a family by the offspring not having biological children. This author recommends that the probable carriers of the disease be sexually sterilized. This decision, however, must remain with the conscience of the individual.

The clinical and physical findings are not dwelt with in this paper as they are well documented in numerous text books. The research that has been reported up to now is scanty; however, a number of centers are at present attacking the

TABLE 3  
SOCIOECONOMIC CHARACTERISTICS

Variable	Total Cases Studied	Male	Female	All
Vocation:	89			
Professional		4	11	8
Self-employed		27	0	13
Skilled		7	2	5
Semiskilled		11	7	9
Laborer		51	7	29
Housewife		0	73	36
Economic Status:	88			
Substantial		14	10	12
Fair		37	47	42
Poor		44	34	39
Very Poor		5	9	7
Education:	81			
College Graduate		3	4.8	3.7
High School Graduate		12.5	24.4	18.5
Other		84.5	70.8	77.8
Military Service:	94			
		12.7	0	6.4
Intelligence:	57			
Above Average		11	14	12.5
Average		64	72	68
Below Average		25	14	19.5

TABLE 4  
FAMILY CHARACTERISTICS

A. Marital status (of 93 patients on which information is available):	
1.	69.6% of males were married
2.	100% of females were married
3.	8.7% of married males had more than one marriage
4.	27.7% of married females had more than one marriage
B. Children of patients (of 79 married patients on which information is available):	
1.	91.4% of males had offspring
2.	84.1% of females had offspring
3.	Mean offspring per male parent is 3.7
4.	Mean offspring per female parent is 3.5
5.	Median offspring per male parent is 4.0
6.	Median offspring per female parent is 5.3
7.	Total offspring per male parent ranged from 1.12, inclusive
8.	Total offspring per female parent ranged from 1.9, inclusive
C. Siblings (of 76 patients on which information is available):	
1.	97% of males were raised in families with siblings
2.	95% of females were raised in families with siblings
3.	The males had 80 brothers, 86 sisters for a total of 166
4.	The females had 91 brothers, 104 sisters for a total of 195
5.	Mean of siblings for males having same: 5
6.	Mean of siblings for females having same: 4.9



problem vigorously.

Five Chapters to Combat Huntington's Disease have been organized throughout Indiana during the past two years. These Chapters are made up of Huntington's families. However, other interested people are welcomed. All physicians should stand ready to help these chapter members when called upon. Stevens<sup>7</sup> recommends that members of the medical profession stand ready to counsel with Huntington's patients, their offspring and kindred.

There should be better diagnosis and reporting of Huntington's Disease on hospital records and death certificates. Investigation tends to suggest that the physician may leave off Huntington's Disease

(which is often known as the "shaking disease" in Southeastern Indiana) from hospital diagnosis and death certificate to aid the family in the concealment of the disease.

Recently, much interest in this disease has been brought about by Marjorie Guthrie, the widow of folk singer Woody Guthrie, who died from Huntington's Disease in 1967.

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Madison State Hospital  
Madison, Ind. 47250

INDIANA STATE BOARD OF HEALTH  
MONTHLY REPORT—June 1973

Disease	Jun. 1973	May 1973	Apr. 1973	Jun. 1972	Jun. 1971
Animal Bites	1849	1038	1011	1732	1467
Chickenpox	536	715	919	436	300
Conjunctivitis	252	336	242	260	171
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	33	27	41	38	28
Gonorrhea	1291	796	755	1114	522
Impetigo	125	112	82	159	75
Infectious Hepatitis	64	41	34	50	39
Infectious Mononucleosis	55	59	115	73	53
Influenza	1433	1310	2129	565	351
Measles					
Rubeola	60	100	105	115	559
Rubella	69	153	212	68	520
Meningococcic Meningitis	2	1	0	1	1
Meningitis, Other	2	1	5	9	5
Mumps	82	151	202	82	510
Pertussis (Whooping Cough)	2	1	7	4	3
Pneumonia	467	545	457	382	257
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	1276	1469	1031	903	577
Syphilis					
Primary & Secondary	28	17	45	13	25
All Other Syphilis	127	84	92	157	87
Tinea Capitis	8	5	6	3	1
Tuberculosis (Active)	80	75	45	59	58



# A Practical Approach To Chemotherapy of Disseminated Breast Carcinoma

WILLIAM M. DUGAN, JR., M.D.  
Indianapolis

**M**OST patients with disseminated carcinoma of the breast eventually are candidates for chemotherapy. The frequency of successful palliation indicates that the pessimism of the past is no longer justifiable. To omit this type of therapy today gives patients less than their due. Any practicing physician is capable of administering *intelligent, safe and successful* chemotherapy. The purpose of this report is to review the current status of drug therapy in metastatic carcinoma of the breast. Before discussing specific methods of treatment I would like to review:

- 1) General guidelines for the chemotherapy of most malignant diseases,
- 2) The proper sequence of palliation in breast cancer, and
- 3) The prechemotherapeutic evaluation of these patients.

## Chemotherapy Axioms

Table 1 lists six chemotherapeutic axioms. An active treatment program not only offers hope of meaningful palliation for the patient but also allows a positive role of participation for the physician. Equally important is the fact such a program cuts down gravitation to quacks.

Today disseminated carcinoma of the breast is incurable. The worth of drug therapy is, then, only as palliative therapy. "Palliation in turn implies that there has to be something

to alleviate."<sup>1</sup> Thus, only significant symptoms should be palliated.

Investigators have now shown that objective chemotherapeutic responses are associated with better as well as longer life.<sup>2</sup> Good risk patients tolerate therapy better than poor risk patients. Small tumors respond better than large tumors. Thus, when proper indications are present, institution of therapy should not be delayed.

## Guidelines for Chemotherapy

Table 2 lists general chemotherapeutic principles applicable to many malignancies. The only way to evaluate the responsiveness of a given tumor is to undertake a clinical trial. An adequate trial requires administration of agents in maximum tolerated doses for a minimum of six to eight weeks. Waiting three weeks after previous radiotherapy or chemotherapy insures that the largest possible dose of an agent can be given. Treatment should be to toxicity or objective response. The margin of safety may be quite narrow. This situation is analogous to the problem of controlling weeds in a lawn—too little weed killer and the weeds flourish—too much weed killer and the grass dies. The objective of an adequate course of chemotherapy is "to make the grass a little brown." If a response occurs, therapy is continued until relapse, using a dose which produces

tolerable toxicity. When there is clear-cut evidence of either no response or progression, therapy is interrupted immediately. Three weeks should elapse before instituting another clinical trial. Proper evaluation of therapy requires responsible medical record keeping. Flow sheets, drawings, and therapy synopsis sheets are particularly useful.

TABLE 1

### CHEMOTHERAPY AXIOMS

1. Therapy is useful
2. Responders live better and longer
3. Chemotherapy is palliation
4. Only symptoms can and should be palliated
5. Chemotherapy is tolerated best by good risk patients
6. Small tumors respond better than larger tumors

TABLE 2

### GENERAL GUIDELINES FOR CHEMOTHERAPY

1. No previous suppressive treatment for 3 weeks
2. Avoid homeopathic underdosage or toxic overdosage
3. Treat to toxicity or objective response
4. With a response, continue active therapy until a relapse
5. With clear-cut progression stop immediately
6. Wait 3 weeks; proceed with another clinical trial
7. Document, document, document!



# Proper Sequence of Palliation

Figure 1 and Table 3 outline the proper sequence in palliating advancing symptomatic breast metastases. Localized soft tissue and osseous disease are first treated with radiotherapy. Radio-resistant local disease and visceral metastases are then treated with hormonal manipulation. Chemotherapy generally is *not* instituted until the patient has failed on radiation and hormonal manipulation. The evaluation period for hormonal manipulation is at least six to 12 weeks. For this reason rapidly advancing, life threatening disease often requires all treatment modalities from the outset. Cerebral, neurologic or ophthalmologic metastases are chemotherapeutic emergencies and require prompt aggressive therapy.<sup>3</sup> Pro-

TABLE 3

SEQUENCE OF PALLIATION	
1.	Local, nonvisual→radiotherapy
2.	Visceral and radiotherapy failures→hormonal manipulation
3.	Hormonal failure→chemotherapy
4.	Presentation with life threatening metastases→often all three modalities: chemotherapy, hormones, irradiation

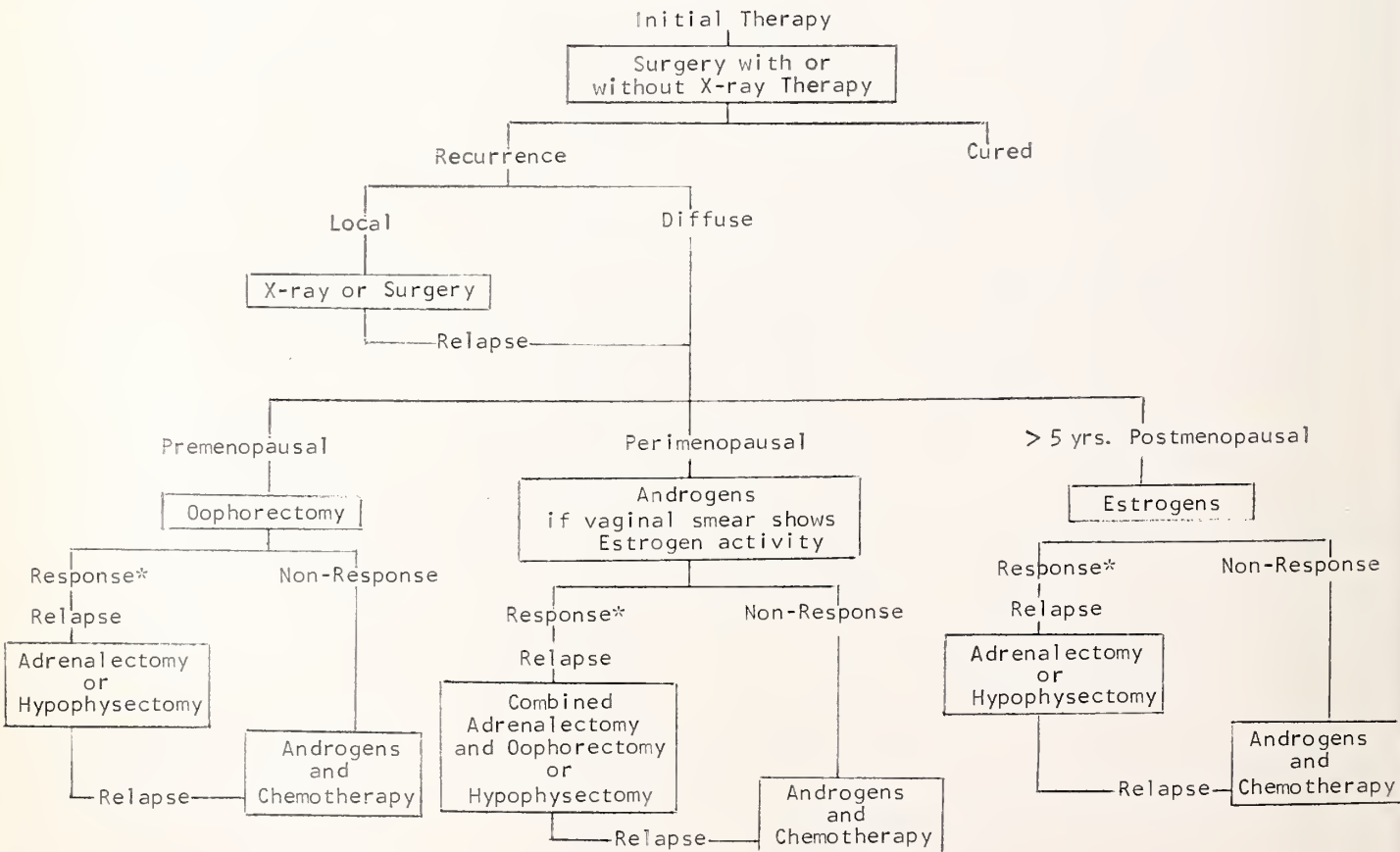
longed survival in these conditions is best achieved by combining chemotherapy, hormonal manipulation and radiotherapy.

Many points about hormonal manipulation deserve emphasis. Hormonal therapy is *safer, easier* to manage, and more likely to give a *prolonged* remission than chemotherapy. In the premenopausal female oophorectomy should not be

done at the time of hopefully curative mastectomy. It has been shown that overall survival is the same whether the procedure is done with initial surgery or at the time of dissemination. The psychological impact of simultaneously losing a breast and both ovaries is under-emphasized. More importantly, however, ill-timed oophorectomy deprives the physician of the most sensitive yardstick in the determination of whether a tumor is hormonally dependent.

In the greater-than-five-year postmenopausal patient, hormonal therapy is all too often done incorrectly. Diethylstilbesterol will give remissions of 30% to 40% in this age group and is the agent of first choice. The stilbesterol dosage is 5 mg orally three times daily.

FIGURE 1  
SEQUENCE OF THERAPY—BREAST CARCINOMA



\* Response is defined as objective remission which exceeds six months in duration.



Nausea and vomiting are frustrating side effects. The importance of giving estrogens is so great that one may initially need to use a dose as low as 1.0 mg per day to avoid nausea and vomiting. The dose is slowly increased as tolerated over days to weeks. A second common pitfall with estrogen use is failure to recognize that the symptoms of nausea, vomiting, constipation and confusion are often caused by the acute development of hypercalcemia. These patients are often incorrectly labeled as "hopelessly and terminally ill." Hypercalcemia usually indicates that one is getting a response to the hormonal agent and should therefore be treated vigorously. This complication can be avoided if multiple routine serum calciums are obtained in the first weeks of estrogen administration. A recent report indicates this complication can occur within 24 hours of therapy with a single 5.0 mg oral dose.<sup>12</sup>

Patients in the perimenopausal group respond poorly to hormonal manipulation and should more quickly be given chemotherapy.

If the initial *objective* hormonal remission exceeds six months in duration, further hormonal manipulation is indicated at the time of relapse and may be expected to achieve another remission 50% of the time. (See Figure 1.) We favor transphenoidal hypophysectomy as the best next hormonal procedure because of: 1) shorter operative time, 2) more "complete" hypophysectomy than by the cranial approach, 3) shorter postoperative convalescence, and 4) less overall morbidity and mortality when compared to adrenalectomy or cranial approach hypophysectomy. At the present time transphenoidal hypophysectomy is not universally available.

TABLE 4

PRE-CHEMOTHERAPEUTIC EVALUATION

1. Complete history and physical
2. CBC, platelet count
3. Chest x-ray, bone survey
4. Serum calcium and phosphorus
5. SGOT, LDH, ALK PHOS, Bilirubin, BSP
6. Serum proteins
7. Urinalysis, BUN, creatinine
8. Bone marrow and bone scan, liver scan, creatinine clearance, if indicated

TABLE 5

POOR RISK PATIENTS

1. Extensive X-ray Therapy
2. Diffuse Osseous Metastasis
3. Impaired Hepatic Function
4. Impaired Renal Function
5. Poor Nutritional Status
6. Advanced Age
7. Metabolic Disturbances
8. Hypoproteinemia
9. Infection

TABLE 6

MYELOPHTHSIC ANEMIA (LEUKOERYTHROBLASTOSIS)

1. Nucleated RBCs
2. Anemia
3. Reticulocytosis, Polychromasia, Stippling
4. Leukopenia, Immature WBCs
5. Thrombocytopenia

TABLE 7

CRITERIA FOR RESPONSE (AFTER ANSFIELD)

1. 50% Decrease in Tumors — No Lesions Show Progression
2. Subjective Improvement
3. Leveling off or Reversal of Weight Loss
4. Improvement in Performance Status
5. Existence of Above Criteria for at Least Two Months

Prechemotherapeutic Evaluation

A careful prechemotherapeutic evaluation of the patient is most important. The workup includes CBC, platelet count, chest x-ray, bone survey, serum calcium and phosphorus, liver function studies, serum proteins, and renal function studies. (See Table 4.) Special attention should be paid to those factors which increase the risk of chemotherapy. (See Table 5.) Previous suppressive therapy, diffuse osseous metastases or myelophthisic anemia (leukoerythroblastosis) may indicate less than normal marrow reserve. In these situations bone marrow and bone scan are important additional diagnostic procedures. Myelophthisic anemia deserves special comment. This term applies to space occupying disease of the marrow of which metastatic carcinoma is the most common etiology. The most regular abnormality seen is the presence of normoblasts (nucleated red blood cells) in the peripheral blood.<sup>4</sup> This finding is significant and should never be ignored. In addition, one may see anemia, polychromasia, stippling, leukopenia, immature granulocytes, and thrombocytopenia. (See Table 6.)

Specific Methods of Treatment

Anti-metabolites and alkylators are the most useful drug classes for management of advanced breast carcinoma. Objective response occurs in 20% to 40% of the patients treated. The criteria for response as defined by Ansfield are listed in Table 7. It is not my purpose to review all the agents or all the treatment programs used in disseminated breast cancer, but to limit this review to the more commonly used,

TABLE 8

CLASS	AGENT	ROUTE OF ADMINISTRATION	INITIAL DOSE	MAINTENANCE DOSE	DOSE LIMITING SIDE EFFECTS
Alkylator	Thiotepa	IV	0.2mg/kg d x 4 d	0.2mg/kg/ q7-14 d	Marrow Depression
	Cytosan	Oral	150-200mg/d	50-200mg/d	Hemorrhagic Cystitis, Marrow Depression
Anti-Metabolite	Flourouracil	IV	15mg/kg/wk	Same	Intractable Enteritis, Stomatitis, Marrow Depression
	Methotrexate	Oral	1.25mg q. i. d.	Same	Stomatitis, Liver Damage Marrow Depression
		IV	25-50mg/wk	Same	

logistically practical schedules. Table 8 lists agents and dosages for good risk patients that can be accomplished on an outpatient basis. Hospitalization is not necessarily required for ambulatory patients.

I would particularly like to point out the method of 5FU infusion. It is given rapidly IV push on a weekly basis to the level of toxicity. This is significantly different than the recommendation in the package insert which suggests 12mg/Kg/day IV for four days, then 6mg/Kg/day IV every other day to slight toxicity. This resulted in a reported mortality of up to 16%.<sup>5</sup> In the middle to late 1960s it became fashionable to dilute the 5FU in a liter of fluid and infuse it over several hours. This was repeated daily to toxicity or to a maximum of 10 days, whichever came first. Response rates were similar and toxicity said to be less. In our hands, however, toxicity was often severe. In 1968 Jacobs reported a weekly schedule of 5FU administration.<sup>6</sup> Results were equally good and toxicity was significantly less. There were no drug related deaths in 129 patients. Jacobs used 15mg/Kg/week IV push for four weeks, then 20mg/Kg/week

(if necessary) to levels producing mild toxicity. The Eastern Cooperative Oncology group investigated three different weekly dosage schedules for 5FU, and Horton reported these results in 1970.<sup>5</sup> There were two drug related deaths in the high dose group.

When giving 5FU, CBCs are obtained each week immediately before giving the next injection. An attempt is made to control GI side effects with symptomatic medication before lowering the dosage. At a time when leukopenia occurs (<4500) either the dose is cut slightly or the interval of administration lengthened to every 10-14 days.

All four drugs (see Table 8) are about equally effective. I think 5FU is the safest and should be the drug of first choice the majority of the time. Some feel methotrexate is a good second agent, particularly if one gets an initial 5FU response.<sup>7</sup> Methotrexate should not be used when renal insufficiency exists, as serious toxicity can result. With the onset of stomatitis, therapy should be interrupted until the oral lesions heal completely and then reinstituted at a lower dosage. With

methotrexate hepatitis a longer cessation of therapy is necessary.

Cytosan is particularly useful when diffuse osseous metastases are the major manifestation of disease and should be the first drug used in this situation. The dose of cytosan is regulated to keep the WBC in the 3000-4500 range. Nausea is lessened by administration with meals. The complication hemorrhagic cystitis results from direct bladder mucosal contact with the breakdown products of cytosan. It is preventable by greatly increasing the fluid intake and giving the medication early in the day. The latter is important because cytosan is rapidly absorbed and excreted. Thus an evening dose would leave the cytosan breakdown products in the bladder overnight.

The results of combination chemotherapy are promising. However, toxicity is universal and deaths not infrequent. Considerable chemotherapeutic experience is necessary before embarking on multidrug programs. Doses of one or more of the agents are constantly being reduced or omitted, depending on specific toxic reactions. One needs



the facilities of a major treatment center for these purposes. Commonly encountered problems include overwhelming septicemia, infections with unusual organisms and the need for blood and platelet transfusions.

In 1966, Greenspan reported a 74% response rate in 113 patients, most of whom received a combination of methotrexate and thiotepa.<sup>3</sup> (See Table 9.) He felt that this combination was particularly useful for skin, subcutaneous, regional pulmonary and central nervous system metastases. He added 5FU to the above two drugs for aggressive disease, especially when hepatic metastases were present.

Cooper reported nearly a 90% response rate in 60 patients with far advanced hormone resistant disease using a very aggressive 5-drug program.<sup>8</sup> (See Table 10). There were two drug related deaths.

Ansfield evaluated a lower dose schedule using the same drugs and reported a 60% response rate in 18 patients.<sup>9</sup> The series included 5FU failures. (See Table 11.)

Preliminary reports on adriamycin indicate 70% response rates when used as a single agent and 30% response rates in multidrug failures.\* This agent is still on clinical trial and not widely available.

In the last three years we have had 25 responses in 32 hormone resistant patients (78%) treated with thiotepa, 5FU, and methotrexate. Most of the patients also received prednisone and dromostanolone.

### Special Application of Chemotherapy

Topical chemotherapy is occasionally useful for ulcerating cutaneous disease. Thiotepa 15 mg is diluted with 20 cc to 30 cc of

\*Einhorn, Lawrence H., M.D.: Personal communication.

TABLE 9 COMBINATION CHEMOTHERAPY — BREAST — GREENSPAN ————— 1966			
AGENT	ROUTE	DOSE	RESPONSE
Methotrexate	Oral	5-10mg qd x 4-9d to antifol Stomatitis	84/113 or 74%
Thiotepa	IV	15mg qd x 4	

TABLE 10 COMBINATION CHEMOTHERAPY — BREAST — COOPER ————— 1969			
AGENT	ROUTE	DOSE	RESPONSE
Oncovin	IV	35mg/kg/wk	53/60 or 90%
Cytosin	Oral	2.5mg/kg/d	
Prednisone	Oral	0.75mg/kg/d	
Flourouracil	IV	12mg/kg/dx4d then 500mg/wk	
Methotrexate	IV	25-50mg/week	

TABLE 11 COMBINATION CHEMOTHERAPY — BREAST — ANSFIELD ————— 1971			
AGENT	ROUTE	DOSE	RESPONSE
Oncovin	IV	1mg/wk	11/18 or 60%
Flourouracil	IV	500mg/wk	
Methotrexate	IV	25mg/wk	
Cytosin	Oral	100mg/after breakfast	
Prednisone	Oral	45mg/dx2 wks then 30mg/dx2 wks then 15mg/d	

water and applied as a gauze soak for a total of 15 to 20 applications on a daily basis.<sup>10</sup>

Adjunctive chemotherapy at the time of mastectomy is not presently recommended. A cooperative study involving 45 institutions is currently evaluating this problem.

An occasional patient may present with isolated hepatic metastases and be a candidate for hepatic artery infusion with 5FUDR.

Malignant pleural and peritoneal effusions are particularly common with disseminated breast carcinoma.

Physicians in the state of Indiana can dial a toll-free number (1-800-382-1579) between the hours of 8:30 a.m. and 5:00 p.m., Monday through Friday, and listen to a six-minute tape which concisely covers this problem.<sup>11</sup> (Indiana Division of the American Cancer Society Teletape System—Tape #129, titled, "Pleural Effusion and Ascites." Indianapolis telephone users call 257-5329.)

### Summary

Most patients with disseminated

carcinoma of the breast eventually are candidates for chemotherapy. Basic guidelines for treatment, the proper sequence of palliation, and the prechemotherapeutic evaluation have been discussed.

The treatment regimen of first choice the majority of time is 5FU in a dose of 15mg/Kg/week undiluted rapid IV push. With failure of 5FU, response can be obtained with: 1) Methotrexate, 2) the alkylators, or 3) combination chemotherapy. Cytosan is particularly useful with disseminated osseous disease.

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# Physician Perceptions of State Health Needs

JOHN SVAAN, PH.D.  
Indianapolis

## Introduction

THE Indiana Regional Medical Program has had a continuing interest in assisting to assess health needs and to determine health priorities in the state of Indiana, and the evolution of the goals and objectives of the IRMP has been a reflection of increased awareness of health needs. Although data were available from a number of sources regarding morbidity, mortality and disability, no recent data were available which reflected the perceptions of physicians concerning health needs. Accordingly, in April 1971 a questionnaire was designed and sent to more than 800 Indiana general practitioners who function as primary care physicians. More than 25% of the physicians who received the survey returned it. There were 207 usable protocols, and a number of others were returned with explanations that the physician was retired or semi-retired, had gone into a specialty practice, or for some other reason was unable to or unwilling to return the questionnaire. In a few instances, the respondent was critical of the survey.

## General Characteristics of the Respondents

Of the 207 physicians who returned usable questionnaires, approximately two thirds described themselves as being in solo practice. A number of the remaining one third who indicated they were in group practice are actually in two-

man partnerships. The typical physician in this survey graduated from medical school in 1952 and is probably in his mid-40s. His estimated weekly caseload is 38 hospital cases and 198 office cases. He treats 93% of his patients without referrals and refers 5% to a specialist. He treats 90% of his patients as outpatients in his own office, treats 7% in the hospital, and places 1% in nursing homes. About 7% of his patients come from outside the county in which he practices, 20% of his patients come from rural areas or from towns with populations of 2,500 or less, and 15% of his patients come from low income families.

Eighty-three per cent of the physicians in this sample accept new patients, although in some cases the physician will do this only if the person is a newcomer to the community. Ninety-five per cent of the sample treat patients who are indigents, and 95% indicate that the hospital serving the community provides emergency room service to some indigent patients. Fewer than one third of the physicians indicated that there are community clinics in their communities that provide substantial health care to indigents.

Responses to this questionnaire came from physicians in approximately two thirds of the counties in Indiana. All 14 state planning and development regions were represented.

## Perceptions of Health Deficits

On the second page of the questionnaire each physician was asked to read a list of 33 health deficits

and needs and to check those resources which are deficient in his community. Space was provided for writing in other needs not included in the list. The respondent was then asked to indicate which were the most pressing needs; to put a 1 beside the greatest need, a 2 beside the second most pressing need, etc. through 5. In determining the high priority needs for the entire sample, the responses were weighted to reflect the greater importance of health needs given high priority rankings, as shown in Appendix A.\* The first 10 high priority needs are listed in order in Table 1.

While the responses of a sample may vary somewhat from the actual but unmeasured views of the total population, a sample of this magnitude allows making reasonable inferences about Indiana general practitioners.

It is obvious from these data that general practitioners believe the greatest single health need in their communities is additional physicians. Although the general practitioner sometimes finds himself without the services of specialists (pediatricians, medical specialists and other specialists), a greater need is additional primary care physicians. By implication, medical needs in the community are greater than he and his colleagues can meet. Thus, either he has a larger patient load than he would wish, or he per-

\*Appendix A shows the entire list of health needs and indicates the relative importance of each health need as reflected in the rankings of the physicians in the sample.

Dr. Svaan is director of Research and Evaluation, Indiana Regional Medical Program, 1300 West Michigan Street, Indianapolis 46202.

ceives that there are numbers of people in the community without the services of a physician.

Another interesting feature of these data is the high incidence of need pertaining to personality and behavior problems. Included among the top six needs are psychiatric services, drug abuse programs and mental health programs. These services generally are required for patients with problems not amenable to symptomatic treatment, who require a greater or lesser degree of psychotherapy.

High Incidence Diagnosis

The last part of the survey questionnaire requested the physician to keep a record for an entire week of the patients he saw in his office. The frequency was then recorded by sex and by three broad age groups for each of 27 diagnoses, which were derived from the Therapeutic Index, National Health Statistics, and Indiana Mortality Data. Several categories like colds, sore throats, and normal pregnancies were omitted. It was made clear in the instructions that completing this part of the questionnaire was optional (in fact, the entire questionnaire was optional and its success depended completely on the good will of the responding physicians). The physician was assured

TABLE 1  
TEN MOST IMPORTANT HEALTH NEEDS  
AS PERCEIVED BY INDIANA GENERAL PRACTITIONERS

Rank	Category	Weighted Total
1	General Practitioners	750
2	Psychiatric Services	277
3	Registered Nurses	261
4	Hospital Beds	247
5	Drug Abuse Programs	215
6	Mental Health Programs	200
7	Pediatricians	170
8	Programs for the Aged	166
9	Medical Specialists	158
10	Other Specialists	147

that the earlier part of the questionnaire which he had already completed would be of value apart from completing the final section.

Almost one fourth of the physicians who completed the first part of the questionnaire also took time to provide information on diagnoses. Forty nine physicians provided information on a total of 6,085 patient visits.\* The 10 most frequent diagnoses are shown in Table 2.

\*The entire list of diagnoses in alphabetical order is shown in Appendix B, with the number of patients indicated. Several categories like colds, sore throats, and normal pregnancies were excluded. Space was provided for writing diagnoses not included on the list, but no strong pattern of other diagnoses appeared.

TABLE 2  
TEN MOST FREQUENT DIAGNOSES REPORTED  
BY 49 INDIANA GENERAL PRACTITIONERS

Diagnoses	No. of Cases	Per Cent of Total
1 Hypertension without Heart Disease	380	6.24
2 Heart Disease, Arteriosclerotic	346	5.69
3 Benign Neoplasm	311	5.11
4 Diabetes Mellitus	293	4.82
5 Hypertension with Heart Disease	282	4.63
6 Neuroses	243	3.99
7 Acute Infections of Childhood	211	3.48
8 Ulcer Syndrome	138	2.27
9 Emphysema	137	2.25
10 Nephritis—Acute/Chronic	130	2.14

It is evident from these data that a large number of patients have cardiovascular problems. When the six categories including heart disease, hypertension, and myocardial infarction (see Appendix B) are combined, they constitute almost one quarter of the patients seen by these physicians in the course of the week. Although many of these patients presumably have comparatively mild conditions, these data are consistent with national and state statistics which identify heart disease as the leading killer. The relatively low incidence of cancer patients, which contrasts with data identifying cancer as one of the three top killers in Indiana and the United States, may be understood in the light of the fact that cancer patients are typically referred to specialists once the disease is identified.

It may be noteworthy that neuroses ranked as the sixth most frequent diagnoses. This is consistent with the relatively high ranking of mental health problems, drug abuse programs and psychiatric services in the list of health needs. It should be borne in mind, however, that the number of patients treated by diagnoses was based on the report of 49 physicians, while the health needs were determined by the responses of 207 physicians.



Although the survey was not designed to determine the degree to which family practice physicians are oriented toward the prevention of disease, there are clues to suggest that a significant proportion of the physician's time is devoted to such measures. One physician reported by telephone that, in the course of keeping records of diagnoses for the purpose of filling out this questionnaire, he and his partner became impressed with the amount of time they were spending on health maintenance and preventive medicine. Occasionally physicians specified other high incidence diagnoses not on the list, and physical examinations and pap smears were often mentioned. In some instances physicians included the worksheets from which they made their summaries, and a casual perusal of these worksheets indicates that the typical physician has multiple cases of pap smears, routine physical examinations and well-baby checkups during the course of the week.

Summary

The questionnaire sent to more than 800 general practitioners in the state of Indiana brought a response of approximately 25%. The responding physicians were well distributed throughout the state. In the estimate of the physicians who responded, the most pressing health needs in Indiana pertain to medical manpower: general practitioners, specialists, and nurses. Needs pertaining to psychotherapy and mental health programs were mentioned with great frequency, as well as the need for hospital beds and provisions for the aged and infirm. Forty-nine of the 207 physicians responding to the survey also kept a daily record of patient visits for one week. Cardiovascular problems represented approximately one fourth of the patients recorded for this survey. The sixth place ranking of neuroses is consistent with the concern the physicians had for provision of psychiatric services and mental health programs in the local

community.

Acknowledgement

On behalf of the Indiana Regional Medical Program, the author wishes to thank the physicians who took time to respond to the survey, particularly those who kept a record of patients seen for an entire week. Thanks are due also to Mr. Aygen Dogar, who first proposed the survey, and to Robert B. Stonehill, M.D., and Florence R. Brown, R.N., who contributed to the design of the study.

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APPENDIX A  
SUMMARY OF PRIORITY RATINGS FOR HEALTH NEEDS

*Rank	Health Needs	**Weighted Score	Rank	Health Needs	Weighted Score
	<b>Quantity of Health Manpower</b>			<b>Availability of Facilities and Services</b>	
1	General Practitioners	750			
7	Pediatricians	170	33	Laboratory Services	21
20	Surgeons	71	32	Blood Bank	27
9	Medical Specialists	158	25	Dental Services	50
10	Other Specialists	147	2	Psychiatric Services	277
3	Registered Nurses	261	31	Cardiac Care	29
13	Licensed Practical Nurses	114	29	Intensive Care	35
16	Therapists	97	26	Physical Therapy	41
14	Social Service People	103	22	Occupational Therapy	58
	<b>Health Related Programs</b>		23	Speech & Hearing Therapy	58
6	For Mental Health	200	21	Cobalt, Radioisotope Therapy	61
17	For the Retarded	94	24	Hospital Outpatient Serv.	54
8	For the Aged	166	28	Hospital Emergency Serv.	38
12	For the Indigent	141	27	Ambulance Services	39
30	For the Partially Sighted or Blind	33	4	Hospital Beds	247
5	For Drug Abuse	215	11	Nursing Home Beds	143
19	For Venereal Disease	83	18	Visiting Nurse Services	84
	<b>Organization</b>				
15	Local Initiative for Organizing Health Related Programs	103			

\*When two health needs had the same score, that need which was checked by the greater number of respondents was ranked higher.  
\*\*The weighted score was computed as follows: if a health need

was ranked first by the physician, it was weighted 6; second, third, fourth, and fifth ranked needs were weighted 5, 4, 3, and 2 respectively; if a need was merely checked, it was weighted 1. The weighted score is the sum of all these weights.

## APPENDIX B

### SUMMARY OF PATIENTS TREATED BY DIAGNOSIS

	No. of Pts.	% of Total		No. of Pts.	% of Total
Accidents, Motor Vehicle	53	.87	Heart Disease, Acute/Chronic	57	.94
Accidents, Non-Motor Vehicle	39	.64	Heart Disease, Other	94	1.54
Acute Infections of Childhood	212	3.48	Hepatitis, Infectious	30	.49
Arthritis and Rheumatism	90	1.48	Hypertension with Heart Disease	282	4.63
Benign Neoplasm	311	5.11	Hypertension without Heart Disease	380	6.24
Bronchitis	37	.61	Myocardial Infarction	69	1.13
Cancer	68	1.12	Nephritis — Acute/Chronic	130	2.14
Cirrhosis of Liver	37	.61	Neuroses	243	3.99
Diabetes Mellitus	293	4.82	Pregnancy, Complications of	117	1.92
Emphysema	137	2.25	Psychoses	44	.72
Fungus	69	1.13	Stroke	32	.53
Gonorrhea	22	.36	Syphilis	4	.07
Heart Disease, Arteriosclerotic	346	5.69	Tuberculosis	27	.44
			Ulcer Syndrome	138	2.27
			Other	2,298	37.77
			High Incidence Diagnosis	426	7.00
Number of Respondents was 49					
Sum of Patient Visits was 6085					

Retirees and dependents of retired and deceased uniformed service members who are denied entitlement to hospital insurance benefits under Medicare at age 65 remain eligible for CHAMPUS. In order to obtain benefits, however, beneficiaries in this situation must have an identification card showing their continuing eligibility. To obtain this card they must present a copy of the denial of entitlement to Part A benefits from Social Security Medicare to a card-issuing agency. In addition, in order to hasten the processing of claims, a copy of the denial of entitlement should also accompany the first CHAMPUS claim submitted to the fiscal administrator after attaining age 65.

\* \* \* \* \*



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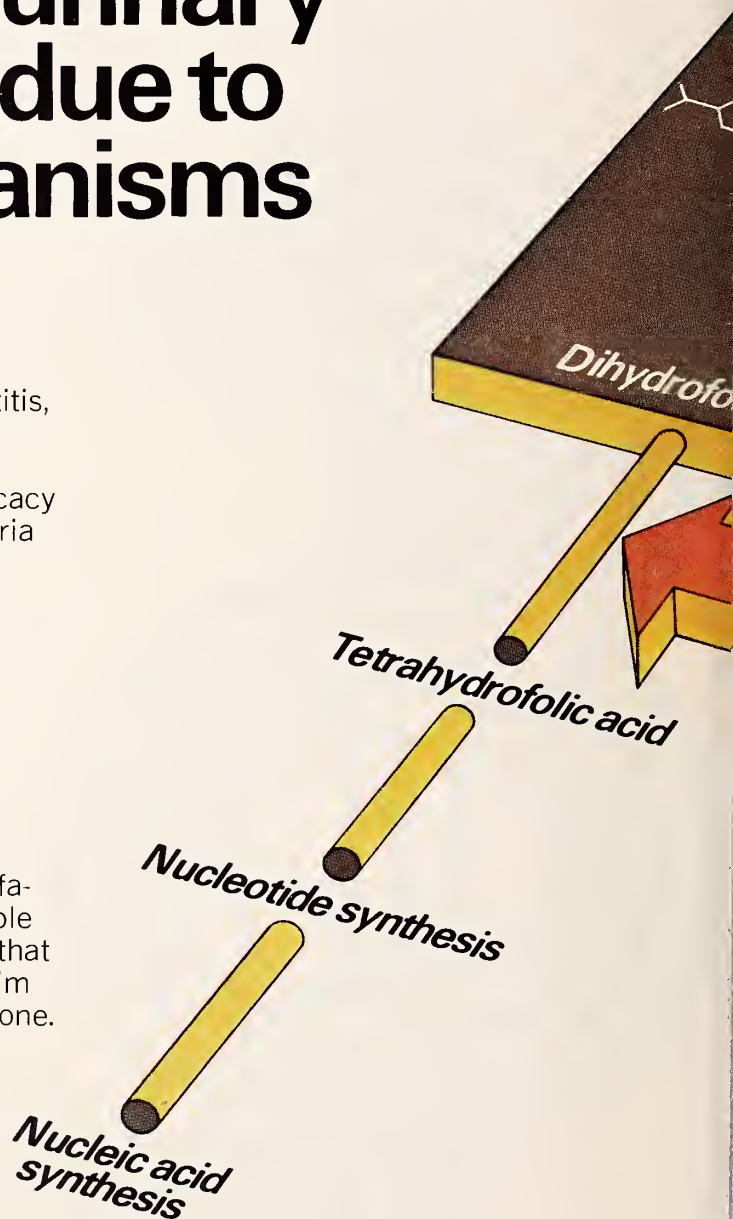
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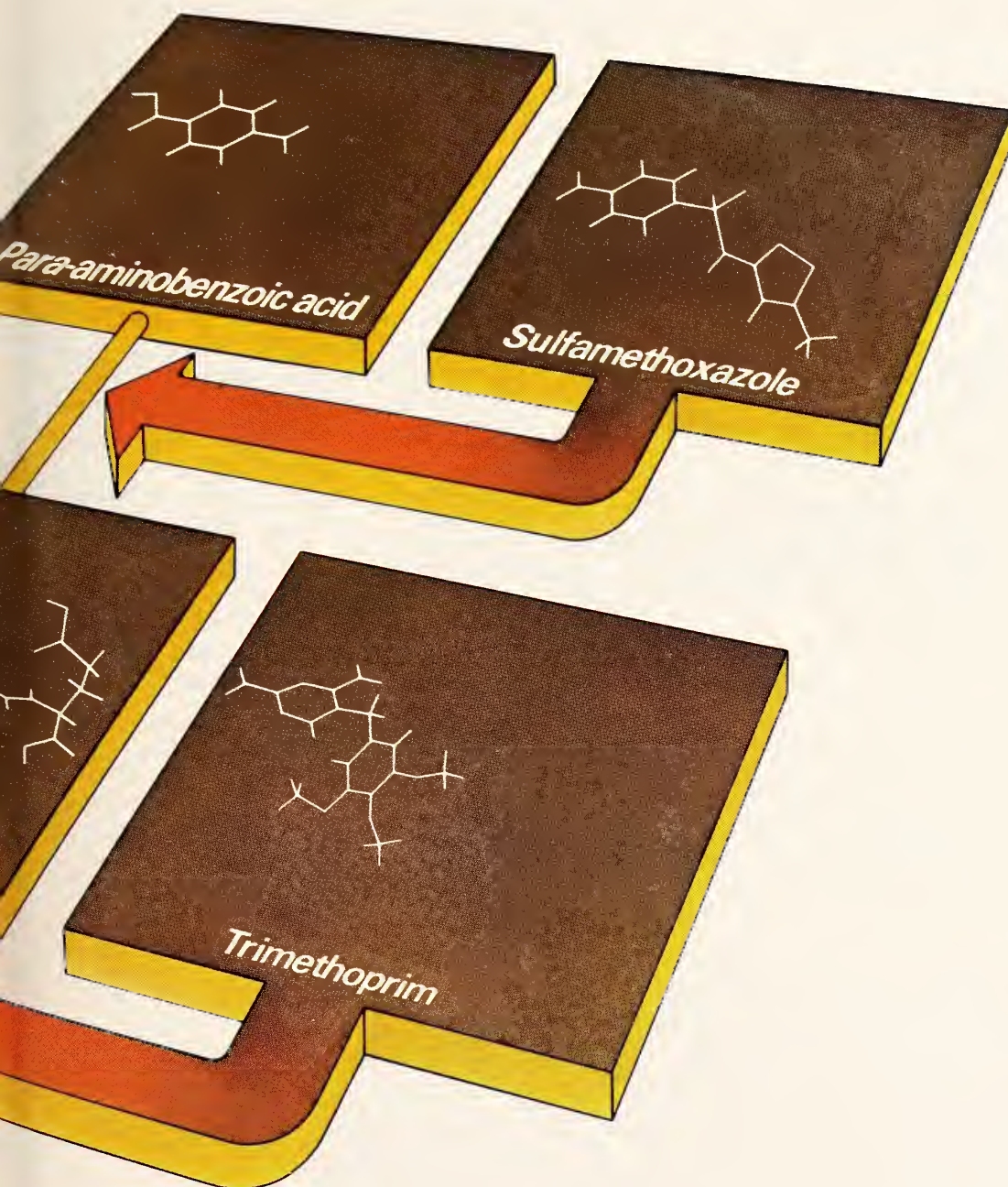
### Bactrim significantly superior to constituents in patients with obstructive complications

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\*Please note that clinical conclusions cannot be extrapolated from *in vitro* studies.





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## Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after ten-day therapy with Bactrim, 68.4% of patients with chronic urinary tract infections maintained response for up to 42 consecutive days, compared with 59.7% with trimethoprim and 44.4% with sulfamethoxazole. In patients with obstruction, 70.8% of those on Bactrim maintained response for up to 42 consecutive days, compared

with 49.4% on trimethoprim and 38.8% on sulfamethoxazole. The figures are particularly remarkable in cases with urinary obstruction—cases regarded as being notoriously difficult to treat.

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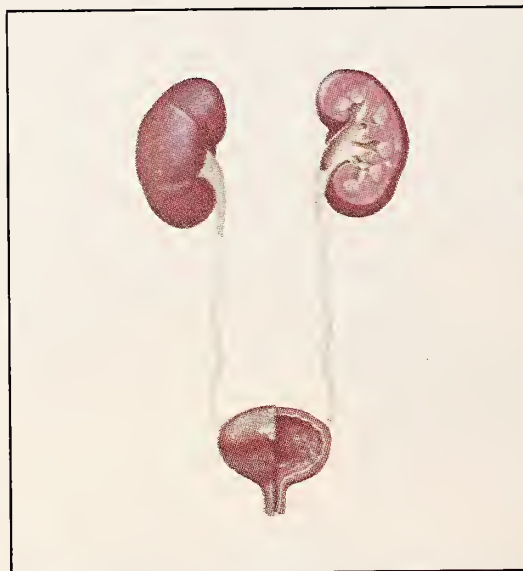
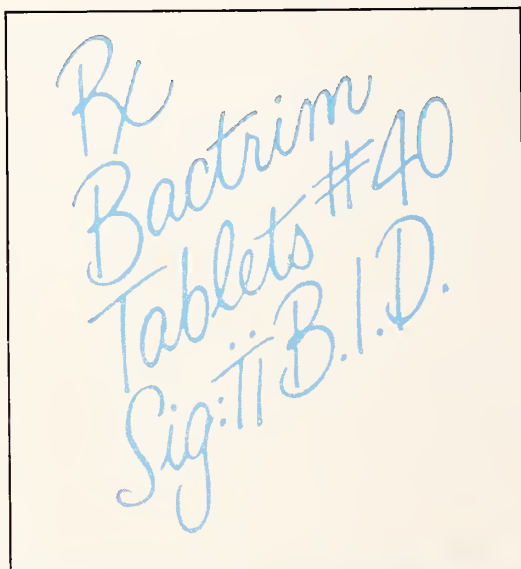
Although Bactrim demonstrated impressive clinical results, it is important to note that the incidence of clinically significant adverse effects was low, mainly nausea and/or vomiting, rash, leukopenia, SGOT increase and creatinine increase.

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**Contraindications:** Evidence or history of blood dyscrasia, active organic disease of the CNS, the first trimester of pregnancy and a history of hypersensitivity to metronidazole.

**Warnings:** Use with discretion during the second and third trimesters of pregnancy and restrict to those pregnant patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers. It is not known whether this can be injurious to the newborn.

**Precautions:** Mild leukopenia has been reported during Flagyl use; total and differen-

tial leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. Exacerbation of moniliasis may occur. In amebic liver abscess, aspirate pus during metronidazole therapy.

**Adverse Reactions:** Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia*, exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the

mouth, vagina or vulva, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified. Flattening of the T wave may be seen in ECG tracings.

**Dosage and Administration: For Trichomoniasis.** *In the female:* One 250-mg. tablet orally three times daily for ten days. Course may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during, and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used,* one 500-mg. insert is placed high





in the vaginal vault each day for ten days and the oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment. Do not use the vaginal inserts as the sole form of therapy. *In the male:* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

**For Amebiasis. Adults:** For acute intestinal amebiasis, 750 mg. orally three times daily for 5 to 10 days. For amebic liver abscess, 500 to 750 mg. orally three times daily for 5 to 10 days. **Children:** 35 to 50 mg./kg. of body weight/24 hours, divided into three doses, orally for ten days.

**Dosage forms:** Oral tablets 250 mg.  
Vaginal inserts 500 mg.

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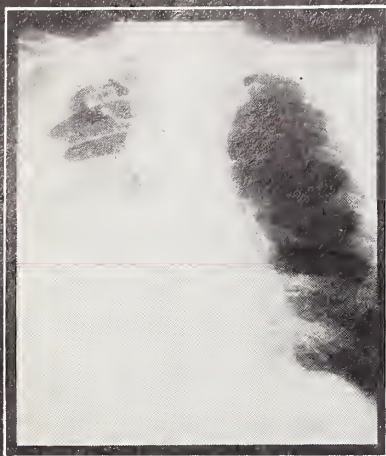
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tablet also contains: aspirin  
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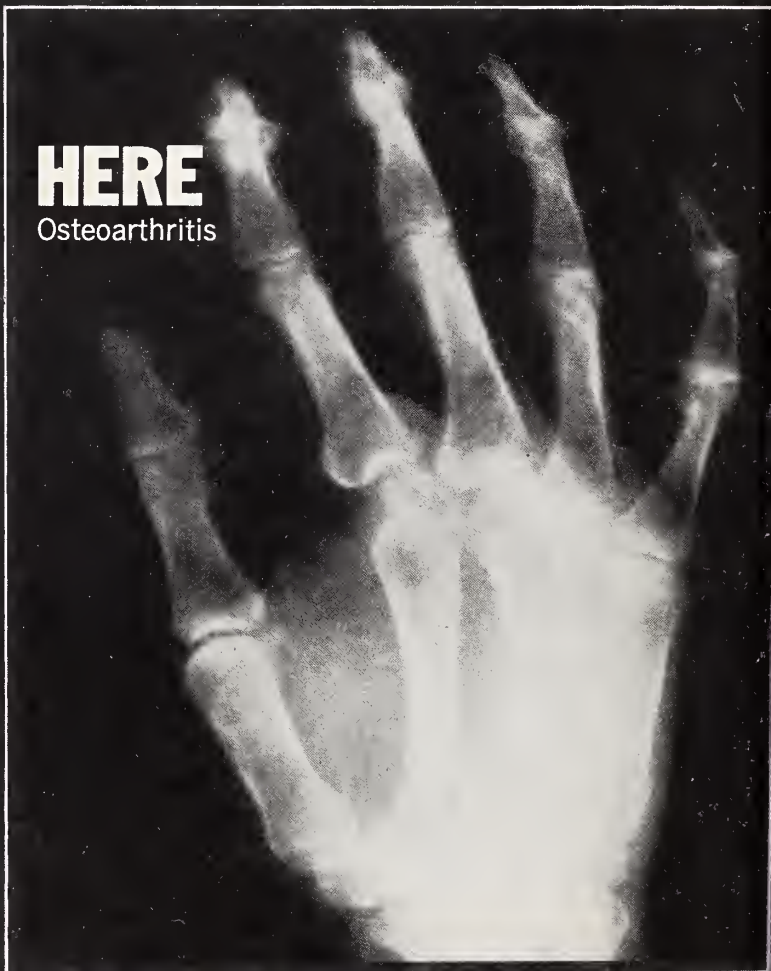


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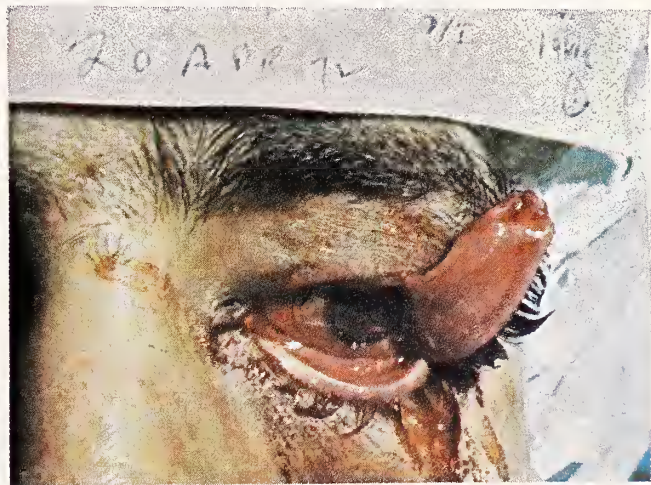
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Requests for reprints should be addressed to Robert William Harger, M.D., 804 Hume Mansur Building, Indianapolis, Indiana 46204.



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## Voluntary Hyperventilation as a Cause of Needless Drowning

SINCE the publication of an article under the above title in this journal in June 1972 the authors have received numerous letters from physicians to confirm the theory that underwater swimming after a period of hyperventilation is dangerous.

W. D. Snively, Jr., M.D., professor of Life Sciences at the University of Evansville, and Mrs. Jan Thuerbach, research associate, hypothesize that, at least in some individuals, vigorous hyperventilation in preparation for underwater swimming is inadvisable.

Hyperventilation is dangerous apparently because it delays the signal which tells the swimmer to surface and breathe until well after the time at which his oxygen supply has fallen so low as to produce unconsciousness.

Without hyperventilation the swimmer enters the water with the carbon dioxide and oxygen supply both at normal levels. Normally the carbon dioxide builds up to a level which triggers the desire to breathe well before the oxygen supply is too low.

However, since hyperventilation depletes the carbon dioxide supply without increasing the oxygen reserve, a hyperventilated swimmer under water may not build up the carbon dioxide high enough to warn of the necessity for breathing prior to the time that the oxygen supply has fallen so low as to produce unconsciousness.

This mechanism probably accounts for the numerous instances in which an accomplished and well-trained swimmer is found drowned under otherwise mysterious circumstances, or is rescued in the unconscious state and resuscitated.

One physician has written Dr. Snively to recount his own experience when he was a member of his college swim team. He remembers hyperventilating prior to a practice underwater swim. And also remembers a feeling of exhilaration and invincibility as his last conscious thought before he was retrieved by his teammates and manually restored to life.

The theory has validity. All swimming coaches and swimming attendants should become acquainted with it. Everyone should caution their families and friends. Medical societies should arrange for public information articles or an-

nouncements in the news media.

Undoubtedly many lives could be saved if the danger of hyperventilation prior to underwater swimming was well publicized.

## Guest Editorials

### Presymptomatic Detection of Huntington's Chorea

HUNTINGTON'S chorea is inherited in an autosomal dominant fashion. Symptoms usually begin after the age of 30, which means that people who develop the disease usually have already conceived their offspring by the time it first appears. The child of an affected parent who has seen the gradual progression of choreo-athetoid movements and mental deterioration to a totally crippled state and death is all too well aware that he himself has a 50% chance of developing the disease. Suicidal depression is not unusual in this group of people. If some effective method were available for detecting the gene for Huntington's chorea before the development of signs and symptoms, it would at least be possible to reassure half of these patients who are at risk.



There are indications that such a test may now be possible. Two groups of workers have recently reported on the use of levodopa in the investigation of people genetically at risk of developing the disease.<sup>1-3</sup> The basis of the test is that patients with Parkinson's disease who are treated with levodopa in high dosage frequently develop dyskinesias, including choreo-athetoid movements very similar to those seen in Huntington's chorea. It is possible that Huntington's chorea is due to an abnormal reaction to dopamine. It is therefore also possible that such movements may be induced by levodopa in asymptomatic persons who are later to develop the disease. In a recent report<sup>3</sup> patients and controls received levodopa in gradually increasing doses to a maximum of 2-5 g daily for a total of 10 weeks. In a second part of the study levodopa at a dose of 800 mg/day was given in combination with a peripheral dopa decarboxylase inhibitor. The age range studied was from 17 to 33 years. None of the 24 controls developed dyskinetic movements on either regimen. However, about a third of the people genetically at risk of developing Huntington's chorea did develop such dyskinetic movements.

Many things need to be elucidated before the levodopa test can be accepted as an effective method for the detection of presymptomatic Huntington's chorea. Though false positive reactions appear to be unlikely, a larger series of normal persons will be required to make certain that an occasional normal person may not develop dyskinetic movements during this test. Moreover, it still remains to be proved that the people who develop dyskinetic movements will in fact go on to the full development of Huntington's chorea. Though they seem likely to do so, a long follow-up of these positive reactors is awaited with interest. Finally, a negative re-

sponse in a person genetically at risk of developing the disease cannot be regarded as proof of the absence of the gene for it. Again a long follow-up will be required to find out the proportion of false negative responses and at what period in the life of the patient a false negative response can be expected to occur.

Until these questions have been answered it will be difficult to know exactly what to tell the patient. In fact it has been discussed whether it is ethical even to carry out such investigations until an effective treatment for Huntington's chorea is available.<sup>4</sup> At present the only reasonable way in which the results of the test may be applied is in advising individuals on the risk of transmitting the disease to children. Many people seek advice on whether there is any sign of their having the disease before they embark on a family of their own. If the reaction to levodopa is positive, it is probably reasonable to explain that there is a possibility that the disease might be passed on to the children even though there is no certainty that the individual himself may develop it. This is the sort of advice that many of them are seeking.—*British Medical Journal*, 2 September 1972, Martin Ware, editor. Reprinted with permission.

1. Klawans, H.L., Paulson, G.W., and Barbeau, A., *Lancet*, 1970, 2, 1185.
2. Cawein, M., and Turney, F., *New England Journal of Medicine*, 1971, 284, 504.
3. Klawans, H.L., Paulson, G.W., Ringel, S.P., and Barbeau, A., *New England Journal of Medicine*, 1972, 286, 1332.
4. Gaylin, W., *New England Journal of Medicine*, 1972, 286, 1361.

## Researchers Right to Use Animals Still Endangered

An editorial in the April issue of *Lab Animal* describes the "heads of UAA (United Action for Animals)

as strident but harmless eccentrics with a small band of followers," and went on to suggest that this organization's comments on animal research should be ignored.

With all due respect to the editors of *Lab Animal* magazine, NSMR must disagree with this evaluation of the UAA. Perhaps the best argument for that disagreement is the full page advertisement that appeared in *The Washington Post* on April 30, 1973.

That ad, paid for by the "strident but harmless eccentrics," castigated the Food and Drug Administration and the Environmental Protection Agency for requiring testing of drugs and chemicals on laboratory animals. Both of these agencies use lab animals in order to determine the safety of agents which will eventually be used for human consumption.

The thrust of the highly emotional ad, aside from the obvious solicitation of funds, was the claim that as long as 20 years ago methods not involving animals were developed to test drugs and chemicals used by man. The suggested substitutive methods were not enumerated, but it can be assumed that the UAA people were alluding to tissue cultures, molds, single cell organisms and computers. Previously distributed literature has offered these as alternatives to animal experimentation.

Consumers and environmentalists—two groups that were being appealed to in the advertisement—applaud regulatory agencies when DES is removed from cattle rations or DDT is banned from pesticides. It would not seem logical for groups that rely heavily on evidence of cancer in experimental animals for justification of product removal from the market to assume a posture of depreciating the importance of animal experimentation. UAA is strident, but not completely harmless.



While such radical groups continue their highly emotional and usually illogical appeals, the public must be kept informed of the real issues and facts. It is safe to assume that neither FDA nor EPA will answer such attacks, so that job must fall to the great number of scientists who are responsible to mankind for both success and failure in the laboratory.

One may not agree with all the rulings or findings handed down by federal regulatory agencies in the health field, but there is little doubt that they are coming down on the side of human welfare and safety.

Does this mean that the kind of criticism levelled by groups like UAA places a higher priority on animals than on man? That would be one possible conclusion to their statements denouncing animal experimentation.

In England, where the tissue culture, mold, and computer substitution cult got its start, enthusiasm for this approach has been squelched by the fact that not a single credible scientist would give it any encouragement.

The leading proponent was candid in his admission that no support could be found for this substitution scheme. It is to the credit of Michael Fryer, founder and president of the Crusade Against All Cruelty to Animals, that he was willing to publish the results of his inquiries and publicly stated: "whilst I realize that this clarification of the position will be a great disappointment to some, nevertheless I cannot stress too strongly that we do our cause more good, whatever the aspect under consideration—by facing facts squarely."

The National Society for Medical Research feels that United Action for Animals or any other such group should neither be ignored nor taken lightly. Researchers who want to maintain their right to use ani-

mals when they feel it is necessary would do well to take a leaf from Fryer's page: "we do our case more good, whatever the aspect under consideration—by facing facts squarely."

The facts are that we must continue educating the public about the need for animal research, and seek ways to communicate with those who hold opposite viewpoints. —*Bulletin of the National Society for Medical Research, June 1973.* Reprinted with permission.

### They Say Doctors' Medicare Charges Are Dropping

A doctor friend of mine telephoned me yesterday to say, rather gleefully, that physicians' medicare charges are dropping.

I was stunned. Not only was I surprised, and a little suspicious, to learn that doctors' fees were declining, but I felt confused because my friend seemed somewhat pleased—or at least proud of the decline.

"Yes," he said, almost gaily, "according to the 'News Flash' published by the Indiana State Medical Association, charges for outpatient care of medicare patients have declined 11.5% from 1966, and surgical charges have dropped 5.2% during the same period."

"I don't understand," I said. "You mean those are the figures for Indiana?"

"No. Nationwide," he said.

I changed the subject. We talked about sailboats and our wives while I mulled over in the back of my head what he had told me. When I was ready to discuss the subject again, I said, "I just don't understand. You mean the doctors are actually getting less for the same services compared to 1966."

"No, not exactly," he said. He explained that while the doctors are, in fact, charging less for their medicare patients, they are in many cases performing less services. Where they would take x-rays in their of-

fices, then try to collect their fee from medicare, they now tell the patient to go to the hospital and get the x-ray. Then the hospital must handle the complicated paper work to be reimbursed by the government. Since the government has set fixed prices it will pay for medical services, doctors frequently prefer to pass this low-profit business on to the hospitals, particularly if the patient is unable to make up the difference between the doctor's normal fee and the smaller amount the government allows.

Meanwhile, the cost of hospital care appears to be rising considerably faster than doctors' fees. This is, perhaps, because of the amount of federal aid that has been pouring into these institutions. Nurses and orderlies and technicians, who used to work for low pay because they wanted to serve the sick and there was no money to reimburse them, have seen that the money now is available, and they want to be paid according to their worth.

This raises an interesting social question: Is it better to have self-sacrificing doctors who treat the impoverished sick without payment, as a grand humanitarian gesture? Or is it better for the government to pay the medical bills of the impoverished sick?

Our society today has judged that the latter alternative is preferable. Having made this judgment, we should not complain about mercenary doctors or ungrateful paupers. For in the eyes of God—and the law—a poor man is entitled to as good medical care as a rich man. This always has been the case in regards to God. But not so as regards the law. When we made the civil law conform to religious law, we weakened the force of free will as an instrument for good. . . .

Perhaps, as human beings grow more perfect, the disadvantages we are experiencing from some of the humanistic legislation of the past



few decades will be overcome. This has occurred in the past. (Consider how well the Victorians of the last half of the 19th Century adapted to the social changes made in the first half of that century.) I see no reason why we cannot again adjust to the future.—George O. Witwer, editor and publisher, *Kendallville News-Sun*, May 22, 1973. Reprinted with permission.

### That "Crisis" In Health Care

THE secret of winning a debate is to define the grounds on which it is conducted. Liberals in Washington have long been conscious of this simple precept, and as a result have been winning debates—and legislative roll calls—from time out of mind. Conservatives seem to have trouble grasping it, and in consequence find themselves repeatedly deliberating which distasteful remedy must be applied to "problems" invented for them by the opposition.

A textbook example of this procedure may be found in current discussion of the "health-care crisis"—in which Teddy Kennedy, big labor, and the liberal media have argued that private medical care is a shame and disgrace which should be corrected by some form of federal health scheme. The Nixon government, the American Medical Association, and a variety of Republican legislators have hopped obligingly into this rhetorical bear trap, saying, yes, there is a health-care crisis but our solutions are infinitely preferable to Senator Kennedy's. The major point at issue—the alleged defects of the private system and the need for federal action—is thus conceded at the outset, and further government intrusion all but assured.

That there is in fact no crisis in private medicine is argued per-

suasively by Marvin Edwards in *Hazardous to Your Health*. The youthful editor of *Private Practice* recounts the history of progress achieved by American medicine, compares our mostly private system to the government-dominated systems of Europe, and shows that major malfunctions of U.S. health care, such as they are, can be chiefly traced to government interference. In addition, he debunks the standard collectivist notions that the fruits of American medical advance have been denied the poor and down-trodden, that there is a shortage of physicians, and that medical prices are excessive.

Edwards observes that U.S. medicine has virtually abolished such once-dreaded and all-too-common diseases as polio, tuberculosis, typhoid fever, and whooping cough. Because of these achievements and other private healthcare gains, average life expectancies have increased dramatically—from 49 years in 1900 to more than 70 years today. Among the more impoverished members of our society, particularly Negroes, life expectancies are lower than those for the population at large—64.6 per cent for Negroes as opposed to 71.3 per cent for whites. But the gap has consistently narrowed and in the later years of life when medical care is increasingly the crucial factor there is virtually no difference at all. (At 65 the average white American male can expect another 13 years of life; the average black American male another 12.7 years.)

Respecting the much-lamented doctor shortage, Edwards shows there isn't any. The ratio of physicians to general population is better in the United States than in the major European countries and is continually improving—from one physician for every 712 Americans in 1960 to one for every 640 in 1969. Since 1965 the number of physicians has increased three times as

fast as population growth, the number of auxiliary medical personnel almost four times as fast. There are problems of availability caused by the proliferation of government medical programs (28,000 MDs now in government service), but the fact remains that physicians and health-care facilities have been produced in impressive quantities.

The point is underscored by Harry Schwartz of the *New York Times* in *The Case for American Medicine*. Like Edwards, Schwartz observes that the "crisis" argument is mostly myth, and that the American people have very properly been slow to answer the shouts of alarm sent up by Senator Kennedy and his ideological familiars. Schwartz points out that there are some 323,000 physicians in the United States and an army of four million health workers all told. In 1970 the nation had about 7,100 hospitals containing 1.6 million beds and these institutions employed more than 2.5 million people. And the numbers are constantly growing; in 1960 the corresponding figure was about 1.5 million employees.

Nor have these results been attained at the exorbitant price suggested by fans of government medicine. Edwards notes that medical costs have risen less than many other items in our inflationary economy, and that health-care prices under a largely private system are considerably lower than they would be with adoption of proposals for added government programs. In recent years Americans have had an annual health-care cost of \$170 per capita; under the Kennedy plan, this cost would jump to \$265. In 1970 Department of Labor statistics showed that medical costs had risen less than such items as meat, poultry, and fish, home ownership, transportation, etc.—despite the fact that the medical system had absorbed enormous wage increases reflected in hospital-room rates.

Most of the furor about medical prices is stirred up by culprits crying "thief." The general drift of medical costs is obviously part and parcel of the national inflation, created by the very liberals now troubling deaf heaven with their cries of excessive cost. The specific cost push on hospital rates—70 per cent of which are dictated by wages—is spurred by the very unions which bemoan the price of hospitalization. To these examples may be added the phenomena of Medicare and Medicaid, which have intensified the inflation-union problem and between them managed to stir up the closest thing to an authentic crisis in the existing health-care system.

Schwartz observes that the principal result of these two programs has been to generate an enormous artificial increase in monetary claims to medical treatment, above and beyond the normal though generous increase in supply. The result has been a further rise in the cost of medical services—which could have been predicted by anyone who had bothered beforehand to examine the economic relations involved. Medical facilities have been flooded by people suffering from minor ailments or hypochondria—which in turn has made things more

difficult for those with really serious illnesses. By removing economic restraints on frivolous resort to medical care, the federal planners have intensified the very problem which "national health insurance" purports to cure.

On the showing of these authors, the need of the hour in American medicine is not to mandate further government intrusion, but to move as rapidly as possible back toward authentic market arrangements. Legislators weighing "national health insurance" should study these two volumes and learn from them to redefine the terms of the debate. —**Book review by M. Stanton Evans in *National Review*, 150 E. 35th St., New York, N.Y. 10016. Reprinted with permission.**

**"Mosquito control today is in a state of crisis."** A report from the National Academy of Sciences points out that the past 30 years have seen dependence on synthetic organic insecticides which, because of environmental considerations, are being phased out. Mosquito control is necessary to accomplish control of malaria, yellow fever, filariasis and dengue, but will be most difficult without insecticides.

**The price of prescription medicine continues to decline.** The Firestone index for 1972 shows that both wholesale prices of prescription products and the adjusted average prescription charge declined by 5% as compared to prices in 1960.

## Editorial Notes . . .

**Researchers at the University of Cincinnati have developed the first implantable thumb joint which can perform the motions that make man's thumb unique in the animal world.** The joint is made of vitallium. It is the size of an average human thumb joint, weighs one-half ounce and operates like a simple hinge.

**The Veterans Administration will conduct smoke movement tests in 10 hospitals to determine the potential movement of smoke and toxic gases in the event of a fire.** An odorless, nontoxic, chemically and thermally stable tracer gas will be used. Based on the results, the National Bureau of Standards will recommend design criteria and operating procedures for smoke systems for new hospitals. ◀



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# "No Fault" Malpractice System Urged

BUFFALO, N.Y.—A new "no fault" system for compensating patients for medical injury is being placed before state legislatures and medical groups for appraisal. It would replace the present system, which is based on a courtroom determination of malpractice.

The U.S. Commission on Medical Malpractice has urged that one or more state governments investigate the feasibility of patient-injury insurance programs similar to workmen's compensation plans, which compensate the injured worker without demanding proof of his employer's negligence.

The recommendation was part of the Commission's report on legislative and administrative ways to cope with problems arising from the increasing flood of malpractice claims. Malpractice litigation is estimated to cost \$100 million annually in the U.S. and is increasing almost 10% each year.

The new system, called "no-fault medical injury compensation," was worked out by social scientists at Calspan Corporation\* under a research contract from the 21-member Commission. It is similar to the no-fault concept which has been gaining strength in the field of automobile accident insurance.

Calspan scientists Edwin W. Roth and Paul Rosenthal, in recommending the concept to the Commission, emphasized the need for conducting several "pilot projects" before ap-

plying it on a wide scale. They suggested it be tried in such settings as newly created Health Maintenance Organizations, Veterans Administration hospitals, U.S. Public Health Service hospitals, and military health-care facilities.

In civilian life, here's how the concept would be applied under a 2,500 word "Model State Law" drafted by the Calspan team, which included medical and legal consultants.

The patient would be eligible to file a claim if medical intervention had "probably, in whole or in part" caused any physical harm or delay in recovery. This would include medical injuries related to "unavoidable accidents and known-risk treatments," as well as all medical injuries now classed as the result of malpractice.

Assistance in filing the claim would be provided, if needed, by a state Medical Injury Compensation Commission.

## *Lawyer Not Necessary*

In an informal procedure, the claim then would be "screened" by a panel of health-care providers. The patient need not be represented by a lawyer, although he could have one if he wished.

The panel's findings would not be binding on the patient or on the insured. It is expected, however, that many claims would be resolved—either discontinued or settled—at this stage, based on the panel's determination of "probable cause."

If the claim was judged well-founded and no settlement resulted, assistance then would be supplied to the patient in obtaining testimony by medical experts.

Final judgement on the claim would be made by a referee, or

panel of referees, at a hearing "conducted with the degree of formality and dispatch normally found with Workmen's Compensation hearings."

The Calspan team recommended that compensation in such cases be limited to what are legally termed "special damages"—medical and hospital expenses, including rehabilitation and occupational therapy; the cost of pursuing the claim, and loss of the injured person's past and future income. No payment would be made for such general damages as "pain and suffering."

The insurance company for the health-care provider against which the claim was placed would pay the portion of losses not covered by Blue Cross and Blue Shield, Medicare, Social Security, and other insurance systems. Administrative costs of running the Medical Injury Compensation System would be paid out of tax funds.

If the patient were dissatisfied with the referee's decision, he could appeal the substance of the decision to the Medical Injury Compensation Board; appeals to the civil court system would be limited to claims of improper procedure.

How much would no-fault medical injury compensation cost the nation? No reasonable estimates can be made, the Calspan researchers say, until data is available from pilot projects.

The bill for alleged malpractice is already high. About 10,000 suits are expected this year. In addition, a professional liability survey by the American Medical Association indicates that, for every individual who files a malpractice suit "there are probably ten times as many who never become aware of the fact

\*On November 17, 1972, Cornell Aeronautical Laboratory (CAL) changed its name to Calspan Corporation and converted to for-profit operation. Calspan is dedicated to carrying on CAL's 27-year tradition of advanced research and development from an independent viewpoint. Calspan is composed of the same total staff, management, and facilities of CAL which operated since 1945 under a federal tax exemption.



that they have legitimate fault claims under the present medical malpractice compensation system."

Certainly the number of claims would rise under the Calspan no-fault proposal, since filing becomes easier and more medical injuries—not just those due to malpractice—become compensable.

On the other hand, legal fees and awards would be reduced. Use of a screening panel should induce early settlement of valid claims, and termination of unfounded ones. Awards would be limited to out-of-pocket costs, rather than including large amounts for "pain and suffering." Successful claimants would not receive duplicate payments, as they do now, from the malpractice insurer and from other insurance such as Blue Cross.

The no-fault system recommended by Calspan was rated the best among a variety of compensation systems (including 430 forms of the no-fault system) assessed. They were scored on 19 characteristics.

"The inherent shortcomings of the (present) tort-liability system for compensating the medically injured makes the system inimical to the basic objectives of high-quality health care delivery," the Calspan researchers concluded.

"An assessment of the attitudes

of the major groups associated with the problems of health care and compensating the injured reveals strong dissatisfaction with the current tort-liability system. It is concluded that no amount of legislative, administrative, or judicial tinkering with the current system could remove its limitations, and thus an entirely new approach is needed."

The tort system, the researchers found, has a very good record for recovery of high claimed losses, "perhaps because such cases tend to be more impressive to attorneys and juries; conversely, small losses tend to be unrecompensed because . . . attorneys are not inclined to accept such cases."

Under the present system, the patient is compensated only if he can prove that substantial negligence was involved in the medical care he received, and that this negligence resulted in injury. The research team found the no-fault system superior in these aspects:

- *Accessibility.* Skilled assistance is offered to the victim in determining whether he did sustain a compensable injury and in filing his claim.

- *Availability of medical testimony.* If the screening panel decides the claim is valid, medical assistance is made available to him for pre-

senting his claim before the referee.

- *End of adversary relationship* between patient and physician, since need to show negligence has been eliminated.

- *Fairer coverage.* Some degree of risk is associated with almost all treatment. "It is accepted by health care providers and institutions that, in the course of delivering health services on a large scale, a small number of patients will be injured."

- *More consistent awards.* Juries now make "dramatically different" awards for similar injuries. Referees would work from compensation schedules, modified by their own wide experience and their judgement of the individual case.

- *Lower legal costs.* No lawyer at all would be needed in the early stages of the procedure, where most cases would be settled. For representation in the later stages, his fee would be regulated, as it is in the Workmen's Compensation System.

- *Lower medical costs.* Physicians would be relieved of the incentive to practice "defensive medicine," in which they seek to avoid malpractice suits by ordering a wide variety of tests, in order to head off any possible charge of inadequate diagnostic effort, and by not employing innovative medical techniques.

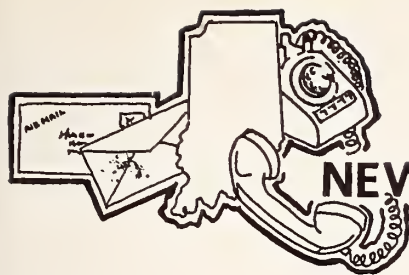
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## NEWS NOTES

### Dr. Snively Named To Indiana Academy

**Dr. William D. Snively, Jr.**, University of Evansville professor of life sciences and a member of the Editorial Board of *The Journal*, was one of 20 prominent Hoosiers inducted into the Indiana Academy June 18.

Dr. Snively, who joined the U. of E. faculty in 1970, has authored over 80 medical articles and 18 books, including "Satan's Ferryman," "Sea of Life," and "Healing Beyond Medicine."

The Indiana Academy, founded in 1970, invites to membership citizens of the State of Indiana in recognition of their contributions to cultural, scientific, literary, civic, religious and educational development within the state.

Dr. Snively received his bachelor's degree from the University of Illinois and his master's and M.D. degrees from Northwestern. He joined Mead Johnson and Company as a medical consultant in 1947 and served the firm over 20 years in positions ranging from medical director to vice president for medical affairs for Mead Johnson International.

He has also been vice president for medical information and consultant for Bristol-Myers Company International.

A member of the Governor's Commission on Medical Education in Indiana, Dr. Snively has been a visiting lecturer at the University of Kentucky, a clinical professor at the University of Alabama, and a preceptor at the Indiana University School of Medicine.

He is a member of the Board of Directors for the Vanderburgh County Association for Mental Health.

### Lilly Makes \$15,000 Grant To Aid Medical Students

National Medical Fellowships, Inc., has been aided by a grant of \$15,000 from Eli Lilly and Company. National Medical Fellowships are designed to help first- and second-year medical students of minority groups. Nearly 1,800 black, Puerto Rican, Mexican-American and American Indian students will benefit this year from a total of \$2.5 million in aid grants.

### PMA Objects to FDA Guidelines For Cough, Allergy Preparations

The Pharmaceutical Manufacturers Association has presented objections to the proposed FDA guidelines governing prescription cough and allergy preparations. The proposed rules were published at such a time as to give interested parties only six days to request an opportunity to testify and only two weeks to study the problem. The PMA points out that the proposed guidelines attempt to determine what the content of a whole class of therapeutic substances may be—a procedure which is not authorized by law. The guidelines

would ban combinations of safe and effective antitussives and/or expectorants or decongestants, although the symptoms which these combinations would relieve are known to occur in 76% of patients with the common cold.

### AMA Announces Three New Community Health Pamphlets

The AMA announces that three new pamphlets are now available. "Statement on Free Clinics," "Statement on Health Outreach," and "Committee on Health Care for the Poor Progress Report" may be obtained free of charge by writing the Department of Community Health of the AMA. Each of the documents was adopted by the House of Delegates at the Cincinnati meeting, November 1972.

### Offer New Film on Depression

Merck Sharp and Dohme have produced a medical educational film entitled "Depression in Medical Practice." It is a 16 mm 24-minute color film, narrated by Dr. Allen J. Enelow of the Pacific Medical Center. The presentation is not oriented to any drug product, but deals with the subject of diagnosis of depression from the standpoint of the non-psychiatrist physician. It is available on fee loan by writing Mr. Clem Hallquist, Merck & Co., West Point, Pa. 19486. A 22-page monograph is furnished to each viewer of the film.

### Science Winner is Hoosier Student

Daniel Gallagher of Michigan City was one of the two winners of the annual International Science and Engineering Fair. Gallagher and Anne Pawlack of Detroit were feted by the AMA House of Delegates at the New York meeting. Displays of their experiments were exhibited at the AMA Scientific Exhibit.

### Dr. Casey Elected

Dr. Edmund Casey, a native of Marion, Ind., will become the first black president of the 117-year-old Academy of Medicine in Cincinnati. He will take over the post in September 1974.

### Dow Gets Cancer Research Contract

The Dow Chemical Company has been awarded a \$148,395 contract by the National Cancer Institute to prepare derivatives of the rifamycin family of antibiotics. The derivatives will be tested later for evaluation in cancer chemotherapy.

### Hypertension Aid Offered

It is estimated that there are at least 11 million Americans with nonsymptomatic hypertension. The fact that hypertension is susceptible to modern day treatment, the fact that such treatment is highly successful, and the fact that most hypertension leads to early heart attack, stroke and untimely death makes it of utmost importance to locate the hypertensives and offer them treatment. The National High Blood Pressure Education Program was created in 1972 to emphasize a campaign of discovery and to encourage patients to take advantage of treatment possibilities. Smith Kline & French Laboratories

Continued



## News Notes

are aiding the campaign by supplying information and material to educate the hypertensive patient. SK&F Professional Representatives will distribute the informational kits and will assist in any way possible.

### Aid for Ill Travelers Available

The International Association for Medical Assistance to Travellers (IAMAT) is a division of the Foundation for the Support of International Medical Training. It maintains a directory of English-speaking physicians located in the larger cities of almost all non-English-speaking countries in the world. It costs nothing to join IAMAT. Tax deductible donations are welcome. For membership write to IAMAT Head Office, 5620 Empire State Bldg., 350 Fifth Ave., New York City 10001. Travelers who join are furnished with a pocket-sized directory listing IAMAT centers with addresses and phone numbers in 400 cities in 116 countries, in addition to a Traveller Clinical Record and Immunization and Malaria Chart.

### Completes Boston Marathon

**Dr. A. M. Hudson, Connerville,** participated in the 77th Boston Marathon, a race covering 26 miles 385 yards and possibly the world's most prestigious running event, turning in a time of 3:29.52.

Dr. Hudson, who runs about 10 miles daily to and from his office, has covered about 3,000 miles over Fayette and Franklin County roads in the last two years.

### Entertains Plastic Surgeons

**Dr. Robert M. Raber, Indianapolis,** had this year's annual meeting of the Ohio Valley Society for Plastic and Reconstructive surgery in Indianapolis during the 500 Festival and Race week.

**DR. JAMES A. GOSMAN, Indianapolis,** president of the Indiana State Medical Association, receives a young tree grown from a seedling from the Tree of Hippocrates, now over 2500 years old and located on the Greek Island of Cos. Making the presentation are (left to right) Phil Cradick, professional sales representative for Schering Laboratories, and James Sallee, district manager. The tree will eventually be planted on the lawn of the ISMA headquarters.



### Gains Nuclear Certification

**Dr. Robert A. McDougal, Indianapolis,** has been certified in nuclear medicine by the Conjoint American Board of Nuclear Medicine, New York. He is the tenth Indianapolis physician now qualified in this field.

### New Services Available

Two new services have been offered recently to ISMA members by Intercept International, Inc. One is the registration of credit cards, I.D. cards and charge plates, and the other is the Emerg-A-Call Record.

Purpose of the former is to prevent major liability due to loss or theft of the cards and plates, while the latter is set up to store such information as next of kin, name and number of physician, special physical conditions and allergies and make this information immediately available in event of serious injury or an emergency situation where one is unable to communicate.

A substantial discount is presently available.

### Medical Staff Chooses Officers

**Dr. E. Gregg Sheehan, Evansville** obstetrician-gynecologist, has been named president and **Dr. John Kelly,** urologist, was named president-elect of the Welborn Baptist Hospital medical staff for the coming year.

Also elected at the staff's recent annual meeting were **Dr. Larry Beisel,** pediatrician, as secretary-treasurer, and **Drs. Luther Downer, Eugene Hendershot and Gilbert Himebaugh** as executive committee members.

### Health Careers Workshop Held

**Dr. Otis Bowen,** Governor of Indiana, gave the opening address at a Health Careers Workshop at Butler University recently.

The closing session, held on the stage of Clowes Hall, was a "Caesarean Birth," narrated by **Dr. W. W. Stogsdill,** chief of the Anesthesiology Department, St. Vincent Hospital, Indianapolis.

### Pike County Honors Petersburg Physician

**Dr. Milton Omstead,** family physician for many of the people of Petersburg and Pike County, was honored recently at the quarterly meeting of the Pike County Board of Health for 25 years of service. Dr. Omstead practiced in Petersburg prior to World War II and, following service in the Army, returned to his practice. He served as Petersburg City Health officer for 20 years and, since the city-county health department was established, has served as vice president and president of the Board of Health.

### 200,000th Patient Registers

On April 19 this year Mrs. Ivan Mays of Portland was registered as the 200,000th patient at Caylor-Nickel Clinic and Hospital. She was presented one dozen red roses from **Dr. Harold Caylor and Dr. Truman Caylor,** sons of the late Dr. Charles Caylor, founder of the clinic. Caylor-Nickel Clinic was established in Pennsville and later moved to Bluffton in 1918.



## Dr. Ladloska Bunker Helping North Manchester Revive Past

"If one person most deserved laurels for keeping North Manchester's past alive, those laurels would belong to **Dr. L. Z. Bunker**," according to a feature story in the *Wabash Plain Dealer* recently.

A retired physician, Dr. Bunker has published a pamphlet discussing the oldest homes in her native city and believes that "because of its wealth of historical sites with structure kept intact, North Manchester should be declared an Indiana historical area."

A 1928 graduate of the Indiana University School of Medicine, Dr. Bunker is a Senior Member of the Indiana State Medical Association.

## More-Effective-Speaker Programs Announced for Three Fall Dates

The AMA Speakers and Leadership Programs to be given this fall have been announced for the weekends of Aug. 31-Sept. 2, Oct. 2-28 and Nov. 16-18. Sessions include theory and drills on message preparation, delivery, fielding of questions, as well as individual coaching and instant TV playback. Programs are held at the Marriott Motor Hotel, O'Hare Airport, Chicago. For further information write or call Mortimer Enright, director, AMA Speakers and Leadership Programs, 535 N. Dearborn St., Chicago, Ill. 60610; (312) 751-6484.

## Dr. Reed Elected CAP Fellow

**Dr. Robert G. Reed, Jr., Columbus**, has been elected a Fellow in the College of American Pathologists. He is an associate pathologist at Bartholomew County Hospital.

## Named Volunteer of the Month

**Dr. B. Trent Cooper, Roanoke**, was saluted by the North-eastern Indiana Chapter of the Heart Association as June's Heart Volunteer of the Month. His services on the local, state and national levels since 1961 were cited.

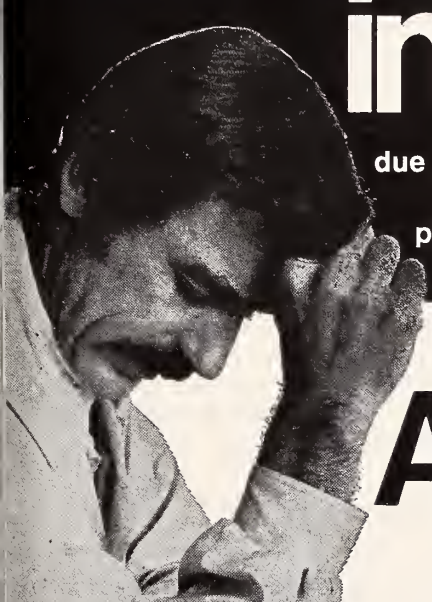
## Dr. Heinrich Re-Elected

**Dr. Weston A. Heinrich, Evansville**, was recently re-elected a director of the Indiana Forum, Inc. The Forum is a non-partisan educational foundation which develops and distributes free reports and films on public affairs issues to the general public.

## Elected Chairman of Miles Board

**Dr. Walter Ames Compton, Elkhart**, was named chairman of the board and chief executive officer of Miles Laboratories, Inc., recently. A graduate of the Harvard University Medical School, Dr. Compton joined Miles in 1938 as medical and research director and had been president since 1964.

Continued



The treatment of


# impotence

due to androgenic deficiency in the American male.

The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

## Android<sup>®</sup>

(thyroid-androgen) tablets



**NEW CLINICAL STUDY**

The Treatment of Impotence with Methyltestosterone Thyroid (100 patients — Double Blind Study) T. Jakobovits Fertility and Sterility, January 1970 Official Journal of the American Fertility Society

**Double-Blind Study and Type of Patient:** 100 patients suffering from impotence. Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% on placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

**Contraindications:** Android is contraindicated in patients with prostatic carcinoma, severe cardiorenal disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone.

**Warnings:** Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.


**Precautions:** If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

**Adverse Reactions:** Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema. Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discontinued as soon as hypercalcemia is detected.

**References:** 1. Montesano, P., and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Trefl, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1967. 4. Hellman, L., Bradlow, H. L., Zameff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endoc 19:936, 1959. 5. Farris, E. J., and Colton, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:653, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

**Choice of 4 strengths:**

<b>Android</b>	<b>Android-HP</b> HIGH POTENCY	<b>Android-X</b> EXTRA HIGH POTENCY	<b>Android-Plus</b> WITH HIGH POTENCY B-COMPLEX AND VITAMIN C
<i>Each yellow tablet contains:</i> Methyl Testosterone . . .2.5 mg. Thyroid Ext. (1/6 gr.) . .10 mg. Glutamic Acid . . . . .50 mg. Thiamine HCL . . . . .10 mg. <i>Dose:</i> 1 tablet 3 times daily. <i>Available:</i> Bottles of 100, 500, 1000.	<i>Each red tablet contains:</i> Methyl Testosterone . .5.0 mg. Thyroid Ext. (1/3 gr.) . .30 mg. Glutamic Acid . . . . .50 mg. Thiamine HCL . . . . .10 mg. <i>Dose:</i> 1 tablet 3 times daily. <i>Available:</i> Bottles of 100, 500, 1000.	<i>Each orange tablet contains:</i> Methyl Testosterone .12.5 mg. Thyroid Ext. (1 gr.) . .64 mg. Glutamic Acid . . . . .50 mg. Thiamine HCL . . . . .10 mg. <i>Dose:</i> 1 or 2 tablets daily. <i>Available:</i> Bottles of 60, 500.	<i>Each white tablet contains:</i> Methyl Testosterone . .2.5 mg. Thyroid Ext. (1/6 gr.) . .15 mg. Ascorbic Acid (Vit. C) .250 mg. Thiamine HCL . . . . .25 mg. Glutamic Acid . . . . .100 mg. Pyridoxine HCL . . . . .5 mg. Niacinamide . . . . .75 mg. Calcium Pantothenate .10 mg. Vitamin B-12 . . . . .2.5 mcg. Riboflavin . . . . .5 mg. <i>Dose:</i> 2 tablets daily. <i>Available:</i> Bottles of 60, 500.

 **rite for literature and samples: BROWN THE BROWN PHARMACEUTICAL CO., INC.** 2500 West 6th Street, Los Angeles, California 90057



## WCICF Elects Drs. McIntosh, Conrad, Hears Talk by Dr. David Edwards

**Dr. Wilbert McIntosh, Terre Haute**, was re-elected president of the West Central Indiana Community Foundation, Inc., recently.

**Dr. Everett Conrad, Brazil**, was re-elected vice president and **Dr. Fred Dierdorff, Terre Haute**, was named to the Foundation.

One of the speakers at the meeting was **Dr. David Edwards**, administrator of Hospital and Health Facilities Programs of the Indiana State Board of Health.

## Offer New Teaching Program For Emergency Medicine

An innovative audio-visual program on emergency medicine for practicing physicians is now available from Health Education Programs, Inc. Entitled "Emergency Management: The First Thirty Minutes," it is a self-instructional program in

which the teaching material, complete with assessment, is incorporated entirely within the audio-visual presentation. No collateral printed material is required. The program is presented in a unique new audiovisual format using the recently developed Norelco PIP projector.

Designed to sharpen the skills required for proper diagnostic assessment and stabilization of the critically ill patient, "Emergency Management" is a comprehensive course in acute care medicine which can be completed on an individual or small group basis.

Each of the 36 programs in the series covers the background and step-by-step technique needed to exercise sound clinical judgment in initiating therapy. The visual material is presented in a combination of live motion pictures, animation and illustration that are explicit in their information content. Each subject is packaged in separate audio and visual cassettes that can be easily loaded into the portable tabletop PIP projector.

"Emergency Management" has been developed under the supervision of **Dr. Stephen E. Goldfinger**, Associate Dean of Continuing Education, Harvard Medical School, and **Dr. James J. Dineen**, Director of the Emergency Training Course, Massachusetts General Hospital.

For complete information on "Emergency Management: The First Thirty Minutes," write to: Health Education Programs, Inc., 65 East 55th Street, New York, N.Y. 10022

## DIRECTOR of MENTAL HEALTH

We are seeking a psychiatrist to direct the Milwaukee County Mental Health Center, a comprehensive community mental health center, organized into six catchment area programs including outreach stations located within the community. 1,000 acute and long-term psychiatric beds; an ultra modern day hospital; and, a soon to be completed 180 bed inpatient resident and day care treatment center for children and adolescents. The Center is a principal psychiatric teaching resource for the Medical College of Wisconsin and has training programs for interns, residents, nurses and other students.

Requires Wisconsin licensure or eligibility for same and at least 5 years comprehensive experience as a mental health director, educator, or administrator preferably in an accredited mental health program, university or hospital.

This is a timely opportunity since we can offer the person appointed to this position the chance to make several critical appointments to new subordinate positions. Excellent employee fringe benefit program and salary. Send vita to:

**Edwin A. Mundy, Director  
Institutions & Departments  
8731 Watertown Plank Rd.  
Milwaukee, Wis. 53226**

## Sponsors Medical Explorers Post

**Dr. Eunice Carter, Noblesville**, is serving as sponsor of the Noblesville Medical Explorers Post, which made a trip to the Crossroads Rehabilitation Center in Indianapolis recently, where the young people saw a film explaining the facilities and history of Crossroads, and then were given a tour of the center. A trip to Riley Hospital was made the following month and an extensive tour taken. At a later meeting Robert Humphrey from the State Board of Health presented a program on venereal disease.

## Two at Evansville Certified

The Vanderburgh County Medical Society *Newsletter* reports that **Dr. Robert J. McElroy** has received certification from the American Board of Internal Medicine and that **Dr. James M. Franco** has been granted certification by the American Board of Neurosurgery.

## Attends National Convention

**Dr. William Gitlin, Bluffton**, reported in the May-June issue of the Indiana School Board Association *Journal* on his attendance at the National School Board Association Convention and a series of spring regional meetings. Dr. Gitlin, who serves on the Bluffton-Harrison School Board, is president of the Indiana School Board Association.

## Appointed County Health Officer

**Dr. William R. Rhyneerson, Fortville**, has been named Hancock county health officer to fill out the term of **Dr. Robert E. Kinneman, Greenfield**, who resigned in January citing "personal health problems."





## ABSTRACTS, BOOK REVIEWS

### DIABETES EXPLAINED

Dr. A. Bloom of London, Eng., University Park Press, Baltimore; 1973; 152 pages with illustrations, tables, diet charts, etc.; \$6.95.

The author states quite clearly that this little handbook is geared to the level of the patient suffering with diabetes. And, indeed, the text is really on a most elementary level; i.e., most of the time.

Any high school graduate should be able to understand the explications being offered. Thus, Chapter 12 listing various diets is the very model of clear simplicity. When we are presented in Chapter 4 a more medical level of the merits and deficiencies of the numerous oral anti-glycemic agents, it seems to me that the author forgets the reader being targeted: the ordinary patient is being given an elaboration that should be given by the attending physician. Even as it is, too many diabetics tend to treat themselves without having the periodic medical check-ups so essential to their well being.

Along the same vein: the author is being a mite oversophisticated in giving the reader diagrams of the pancreas: its location, relation to other organs and structure. We can be indulgent on this score. But then, in Heaven's name, Why take a whole page with the *structure* of insulin: all 51 amino-acids in their exact sequence and including the four S—S bridges? How many *experts* in the field can give this off-hand?

All these strictures do not change the fact of this being an excellent primer on diabetes. The paper, printing and binding are superb and the price really quite within reason.

ARNOLD LIEBERMAN, M.D.  
New York

### HARRISON'S PRINCIPLES OF INTERNAL MEDICINE

Wintrobe, Thorn, Adams, Bennett, Braunwald, Isselbacher & Petersdorf, sixth edition, McGraw-Hill—Blakiston Division, NYC—over 2,000 pages with innumerable charts, tables and color plates, with nigh 200 contributors, divided into Nine Sections and further subdivided into over 400 parts. \$30.00

Textbooks on Medicine are increasing steadily in numbers and this entire field has become highly competitive. In my review of the 5th edition (*JISMA*, March 1967, p.342), I stated that "it is a most formidable competitor to the other contemporary publications in this exacting field." The present, greatly enlarged, 6th edition reinforces my comment, double in spades!

The unique use of the entire first three sections to "The Physician and the Patient," "Inheritance and Growth" and "Cardinal Manifestations and Approach to Disease" are marvelously good teaching material; I would recommend an occasional re-reading of them to even the most sophisticated clinical professor.

Spot-checking some of the rapidly expanding (and changing) areas on the frontiers of medical progress, I really find nothing to deprecate. The hand-picked experts have given their all and done so with decisive precision and crispness.

The paper, binding and printing are truly superb. At the stated price this teaching text and reference monograph is not to be caviled. I'll use it often and continue to thank the authors for the information so readily obtained!

ARNOLD LIEBERMAN, M.D.  
New York

### THE METABOLIC BASIS OF INHERITED DISEASES

John B. Stanbury, M.D., James B. Wyngaarden, M.D., Donald S. Fredrickson, M.D. Third Edition published by McGraw-Hill Book Co., 1972; 1777 pages; innumerable figures and tables; in 12 parts and 74 chapters; \$35.00.

Compared to the previous edition of only a decade ago, this monumental treatise has grown by at least a third in overall size. This is only a reflection of the logarithmic development in this specific area of medicine. Just as an example: Chapter 68, starting on page 1605, discusses incisively the latest on the problem of CYSTIC FIBROSIS (called mucoviscidosis, by some). In 15 fact-packed pages, our present knowledge of the condition is presented in most balanced style. At the end, no less than 334 references are listed!

Have you ever heard of Acatalasemia? Well, read chapter 73 and look at the 177 references immediately following and you surely will know just about all that anybody knows on this rare disorder.

Anything having genetic factors in its etiology is studied in depth, with clear precision in all but rudimentary language. This masterpiece continues to retain its premier position as being THE authority in its chosen field! The paper, type and binding are impeccable. The reader would do well to have this monograph handy in a place where he can pick it up and read the passages pertinent to his problems.

ARNOLD LIEBERMAN, M.D.  
New York

### CLINICAL DISORDERS OF FLUID AND ELECTROLYTE IMBALANCE

Second Edition, edited by Morton Maxwell, M.D., and Chas. R. Kleeman, M.D., some 44 contributors. Published by Blakiston Division of McGraw-Hill Book Co., New York; 32 chapters; 1142 pages.

This tremendous monograph, while containing the word "clinical" in its title, is rather exhaustively aimed at the research workers in the various compartments of the previously single frontier of Medicine.

Nevertheless, if one is prepared to read patiently and not expect crisp, concise answers to his questions, there is surely much to be gained by the in-depth approach of the various authorities. In fact, some of the chapters are genuine clean, concise analyses of the problem in hand. I liked the decisive Chapter 26 on "Diabetic Acidosis and Coma"; not a wasted word! Chapter 24 on "Water and Electrolytes in G.I. Diseases" was a mite long for my taste but that is just my personal reaction. In this chapter there is an interesting photo of a chap who recovered from cholera after receiving no less than SIXTY liters of fluid in just a few days (to compensate for the intense diarrhea)! This is an important clinical observation.

But why go on? Try it; you may like it!

As usual, the printing, binding and paper are excellent. I



## ABSTRACTS, BOOKS

continued

found only a couple of insignificant typo errors. It is really a genuine tour de force!

ARNOLD LIEBERMAN, M.D.  
New York

## STRATEGY OF THE VIRAL GENOME

Ciba Foundation Symposium edited by G.E.W. Wolstenholme and Maeve O'Connor, Williams & Wilkins Co., Baltimore, 1971; 406 pages with many illustrations; two dozen collaborators; \$15.75.

Ever since the end of WWII, the Ciba Foundation has been sponsoring each year several colloquia for the specific purpose of having a free exchange of information (and lack of it) between scientists working in areas where real knowledge was just beginning to be garnered. Today we are already forgetting that not so long ago the very existence of viruses could only be suspected, not proven! Our techniques lacked the magnifications needed for us to be sure they were really there! The electron microscope, radio immune fluorescent scanning, delicate electro immune phoretic procedures, etc. are that recent!

Now, what is a *genome*? Most baldly stated, it is a complete set of hereditary factors such as contained in a *haploid* set of chromosomes. So: how is it possible for some strands of DNA or RNA—single or double stranded—to maintain an independent existence as VIRUSES, to insinuate themselves into bacteria, and then proceed to alter the future of the organisms they have parasitized?

This whole symposium is devoted to the solution of this problem—as far as we have gone. What happens? How does the virion infect? What is its actual structure? Are there, or aren't there, essential and novel virion enzymes?

Clearly, we are only at the beginning of our comprehension of what gives. No less clearly, we can already discern the enormous potentialities of our increasing knowledge. The binding, paper and printing are impeccable. This interim report deserves repeated reading: it has SO much to offer.

ARNOLD LIEBERMAN, M.D.  
New York

## MEMBRANE STRUCTURE AND ITS BIOLOGICAL APPLICATIONS

Annals of the New York Academy of Sciences, Vol. 195, June 20, 1972; 520 pages, soft bound, in six parts; edited by Dr. David R. Green.

This is a truly formidable collection by *the* experts in this burgeoning frontier of science gathered to discuss the latest: what seems proven, what is doubtful and what seems clearly outdated and erroneous. The M.D. feels rather lost and even the gathered specialists make perfectly clear that their reports are strictly interim and subject to continuing corrections as more factual data are gathered and the structure and functions of membranes (wherever they may be) are analyzed on the molecular level! We have come a long way, indeed, from the "simple" Danielli model that was the *dernier cri* only a short decade ago.

Personally, I am quite intrigued by the sophisticated discussion of "Rhodopsin: Conformational Changes in a Membrane Protein." The exact mechanism of the transformation of the light impulse to a nerve propagated flow of energy still eludes the experimenters, but even what they know already

makes fascinating reading. (See p.439 on.)

When the basic properties of myelin are delineated, will we be able to use immunorepression as therapy in certain quite hopeless—presently—human ailments?

The present complexity just may—and sooner than we now believe—be reduced into relatively simple axioms as our knowledge expands. This has happened in other fields. Let us hope that the membranes will be no exception!

ARNOLD LIEBERMAN, M.D.  
New York

## Abstracts From Various Literature, Prepared by AMA

### CROSS-SENSITIVITY AND AMINOGLYCOSIDE ANTIBIOTICS

W. F. SCHORR et al. (630 S. Central Ave., Marshfield, Wis. 54449)

*Arch. Dermatol.* 107:533-539 (April) 1973

Twenty neomycin-allergic patients as well as 50 normal control volunteers were studied by applying 48-hour patch tests in varying dilutions of neomycin, gentamicin, and a new aminoglycoside antibiotic, ambutyrosin (CI-642). Intradermal tests to all antibiotics on all patients as well as control volunteers were also performed. False-positive patch tests or intradermal responses did not occur in 50 control volunteers to any of the concentrations used. In the 20 neomycin-allergic patients cross-sensitization existed with gentamicin (55%) and CI-642, ambutyrosin (90%); CI-642 should not be used to treat neomycin-allergic patients when it becomes commercially available.

### ANAEROBIC EMPYEMA THORACIS

K. M. SULLIVAN et al. (K. N. SULLIVAN, V.A. Hosp., Seattle 98108)

*Arch. Intern. Med.* 131:521-527 (April) 1973

Anaerobes, primarily bacteroides and anaerobic streptococci, were detected in 19% of 226 culture-proved empyemas treated since 1950 at five Seattle hospitals. Anaerobic empyemas existing on admission were often chronic and associated with complicated pulmonary infections in older men. However, anaerobes were isolated from empyemas of diverse cause, and no unique association with specific diseases was noted. Most anaerobic empyemas were loculated and difficult to evacuate; 43% of patients required open drainage. Mortality was 22% for aerobic and 19% for anaerobic empyemas. Progressive local infection, chest wall cellulitis, and metastatic abscesses were not observed. Actual incidence of anaerobic empyemas probably exceeds 19%, since culture-positive empyemas represented only 47% of all patients with empyema. Omission of anaerobic cultures would have raised the number of culture-negative empyemas by 14%.

### CONTINUOUS WEAR OF HYDROPHILIC CONTACT LENSES

H. M. LEIBOWITZ et al. (80 E. Concord St., Boston 02118)

*Arch. Ophthalmol.* 89:306-310 (April) 1973

A hydrophilic contact lens was fitted on the normal right cornea of 10 informed volunteers and worn continuously for 10 days. No evidence of an overwearing syndrome was encountered in any of the subjects. Edema and a burning sen-



sation occurred in several subjects, but these symptoms were transient, minor, and self-limited. Some variability in visual acuity was noted and the cause of this finding is discussed. A small increase in total corneal thickness, not exceeding 30%, occurred in all subjects on the first full day of contact lens wear but did not interfere with vision. The cornea stabilized at this new thickness and no further increase occurred.

**INCIDENCE OF CANCER AMONG MICHIGAN NURSE-ANESTHETISTS**

T. H. Corbett et al. (USVA Hosp., Ann Arbor, Mich. 48105)  
*Anesthesiology* 38:260-263 (March) 1973

A survey of the 621 female nurse-anesthetists in Michigan was performed to determine the incidence of malignancy in this group. Two separate mailings and telephone interviews resulted in a response rate of 84.5%. A total of 33 malignancies in 31 nurse-anesthetists was reported. Several unusual types were noted. Ten malignancies, including three skin cancers, were diagnosed during 1971. Excluding skin cancers, the expected incidence adjusted for age distribution based on statistics from the Connecticut Tumor Registry is 402.8/100,000. The adjusted incidence in Michigan nurse-anesthetists is 1.333.3/100,000. This difference is significant at the 3.1% level.

**ROLE OF ACID IN PATHOGENESIS OF ASPIRIN-INDUCED GASTROINTESTINAL EROSIONS AND HEMORRHAGE**

A. R. COOKE (V. A. Hosp, Dept. of Internal Medicine, Iowa City 52240)  
*Am. J. Dig. Dis.* 18:225-237 (March) 1973

When aspirin is in a soluble and alkaline buffered form, as acetylsalicylate, so that gastric acid is neutralized, it does not change mucosal permeability or cause damage to the stomach. However, aspirin in an unbuffered form, as acetylsalicylic acid, increases gastric mucosal permeability which results in cell damage, exfoliation, and erosions. Reduction of gastric acid abolishes gastric damage caused by aspirin.

**NONMEDICAL USE OF METHAQUALONE**

M. C. GERALD (Ohio State Univ. School of Medicine, Columbus 43210) and P. M. SCHWIRIAN  
*Arch. Gen. Psychiatry* 28:627-631 (May) 1973

The patterns and pharmacological effects of the nonmedical use of methaqualone, a nonbarbiturate sedative-hypnotic, were determined in 66 respondents (median age 22 to 25) residing in Columbus, Ohio. Sixty percent took this drug at least weekly, with 10% once or more daily. The mean duration of drug use was one year, with 20% in excess of two years. The average single and total daily doses, taken orally, were 530 and 724 mg, respectively; marihuana and alcohol were commonly used concurrently. The major effects of methaqualone use were euphoria, relaxation, and relief from anxieties; parasthesia was frequently reported. About one third of the subjects developed degrees of psychological and physical dependence after long-term drug administration. ◀

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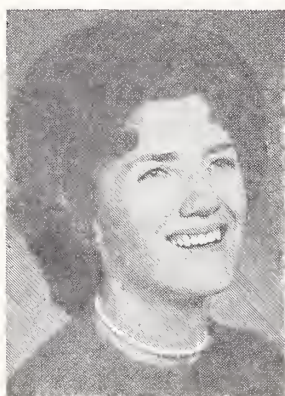
A Subsidiary of 



# *The Woman's Auxiliary* REPORTS TO ISMA

FOCUS — This is the keyword in the Woman's Auxiliary to the American Medical Association for 1973-74. When the House of Delegates convened in New York City under the gavel of Mrs. Robert Beckley, national president, I was proud to be representing the 2600 Indiana members. Joining me were 11 other delegates and alternates from around our state. With 90,000 Auxiliary members nationally, a great many things can be accomplished through organized activity.

Mrs. Willard C. Scrivner, the newly installed president, said in her inaugural address, "while recognizing the talents, ideas and contributions of individuals from all over this great country, it would seem the most fruitful results occur when the group action prevails. With biased attacks by government, news media and consumers, it behooves us to present a united front to our critics. We do not have the time nor can we afford prima donnas or splinter groups if we are to maintain effective leadership in protecting and improving the health of our fellow citizens. (Remember, the banana that leaves the bunch gets skinned)."



An official physicians' survey revealed improved communication and public relations among their top priorities. Just think what a P.R. job we could do if every eligible physician's wife joined our ranks. (In Indiana, that's a member in good standing with the ISMA and his local medical society). Information (giving out) and communication (getting through) are two more key words in our future. The focus will be mainly on membership, legislation, public relations, health education, health services (including children and youth), the abused and battered child syndrome, and safety. Surely among these is something for everyone!

In Indiana we will be emphasizing most of these as well as a continuing interest in the many other Auxiliary programs. Our tasks as an Auxiliary are many, our goal clear, and that is to aid the medical profession in its objectives and work for improvement in the quality of life through better health care for every American.

To our critics we may well say, blaming the medical profession alone for health care deficiency is as plausible as placing the blame for inferior education and leaky toilets on teachers and plumbers. And we might properly add, when they hammer us with the advantages of other countries' medical systems: What new medical system will reverse highway deaths, inner city homicides? What new medical system will do away with the drug culture destroying our youth in too many cases? What new medical system will keep psychotic parents from battering their babies to bloody pulp? Certainly none of the systems existing in less democratic countries than America!

It seems there is a strong desire and uniting effort among physicians to tell their view and provide workable solutions to improve health care with quality medical care at acceptable costs. Functioning through our programs and projects, the doctors' wives can serve as catalysts, leaders and opinion makers along the general guidelines and policies of the AMA.

Mrs. W. W. Stogsdill, President  
Woman's Auxiliary to ISMA



# FUTURE MEETINGS, SEMINARS, COURSES

## Polytomography Symposium Set

The 8th two-day Symposium on Polytomography of the Temporal Bone will be given under the auspices of The Wright Institute of Otology at Community Hospital, Indianapolis, September 29 and 30.

Subjects covered are: "Basic Anatomy of the Temporal Bone" and "Technique of Polytomography of the Temporal Bone" with demonstrations of normal tomograms. Pathological conditions revealed by polytomography, such as cholesteatoma, ossicular chain problems, otosclerosis, fractures, foreign bodies, tumors, and congenital anomalies are shown on original tomograms and the clinical applications discussed.

Number of registrants is limited to 20. Fee for the course is \$150.00.

Inquiries should be directed to: The Wright Institute of Otology, Inc., Community Hospital of Indianapolis, Inc., 1500 North Ritter Avenue, Indianapolis, 46219.

## Kentucky Schedules Symposium On Nephrology for Sept. 21-22

A two-day seminar on Nephrology for practicing physicians will be offered by the University of Kentucky College of Medicine next month. Guest lecturers will join with faculty members in presenting the program. A football game between the Kentucky Wildcats and the Crimson Tide of Alabama in the University's new stadium on Saturday afternoon is an added attraction.

"Nephrology for the Practicing Physician" will be held at the U.K. Medical Center, September 21-22, 1973. Program chairman: Dr. Robert G. Luke. Registration fee: \$40.00. Seven (7) hours of AAFP credit have been requested. For further information contact Ronald D. Hamilton, M.D., Director, Continuing Education, College of Medicine, University of Kentucky, Lexington, Kentucky 40506.

## U. of Kentucky, Indiana U. To Offer Cardiology Program

The University of Kentucky College of Medicine and the Indiana University School of Medicine have jointly organized a program covering a thorough review of the most important recent developments in the practice of Cardiology. This unique "progress report"—sponsored by the American College of Cardiology, Krannert Institute of Cardiology, and the Kentucky Heart Association—focuses on the reasons for the changing concepts and identifies the obsolete, the erroneous, and the misleading ideas, theories, and methods of practice.

"Changing Concepts and Methods in the Practice of Cardiology: The Obsolete and Old-Fashioned vs. Modern and Advanced" will be held at the University of Kentucky Medical Center October 1-3, 1973. Program chairmen: Borys Surawicz, M.D., University of Kentucky, and Charles Fisch, M.D., Indiana University. Registration fee: \$100.00 for members of the American College of Cardiology; \$125.00 for non-members

of the College. For further information contact Ronald D. Hamilton, M.D., Director, Continuing Education, College of Medicine, University of Kentucky, Lexington, Ky. 40506.

## Family Review Program Offered

The University of Kentucky, College of Medicine, will offer a Family Medicine Review (FMR) program in October. Approximately 70 - 75 topics will be presented by University of Kentucky faculty and guest faculty from other schools.

The Fourth Family Medicine Review will be held at the U.K. Medical Center October 7—13, 1973. Program chairman: Frank R. Lemon, M.D. Registration fee: \$185. 54 hours of AAFP credit has been requested. For further information contact Ronald D. Hamilton, M.D., Director, Continuing Education, College of Medicine, University of Kentucky, Lexington, Ky. 40506.

## Chest Physicians to Meet in Canada

The 39th Annual Scientific Assembly of the American College of Chest Physicians will be held October 21 to 25 at the Four Seasons Sheraton Hotel, Toronto, Canada. Registration fee information and advance registration forms are available by writing the College at 112 E. Chestnut St., Chicago 60611.

## Gastroenterologists Set PG Course

The American College of Gastroenterology will conduct its annual Postgraduate Course in Gastroenterology at the Biltmore Hotel, Los Angeles, on October 25 to 27, immediately following the Annual Convention of the College. The course will be devoted primarily to review and assessment of new developments. For full information write the College at 299 Broadway, New York City 10007.

## Interstate PG Medical Association Schedules Fall Meeting at Chicago

The Scientific Assembly of the Interstate Postgraduate Medical Association will be held at the Palmer House, Chicago, October 29 to November 1. This is the 58th annual meeting. The registration fee will be \$25 if paid prior to the meeting and \$40 at the meeting. The program outline and hotel reservation data may be obtained by writing Dr. Alton Ochsner, P.O. Box 5445, Madison, Wis., 53705.

## Computer Medicine Meet Planned

The Third National Conference for the Society for Computer Medicine will be held in Denver November 8 to 10. The program consists of sessions on all the possible medical uses of the computer. For full information write Joseph M. Edelman, M.D., 244 Peachtree Blvd., Baton Rouge, La. 70806.

Continued

### Louisville U. Invites Physicians To Congenital Defects Conclave

A Symposium on Congenital Defects will be conducted by the Department of Pediatrics of the University of Louisville School of Medicine on November 8 and 9, at the Health Sciences Center Auditorium in Louisville. For information write to Dr. Billy F. Andrews, 226 E. Chestnut St., Louisville 40202.

### Announce Medical Seminar Cruise

The Albany Medical College plans to conduct its fifteenth medical seminar cruise in January 1974. It is to be a 14-day cruise from New York aboard the "Rotterdam." Ports of call include St. Maarten, Montserrat, Barbados, Trinidad, Martinique, Puerto Rico and the Virgin Islands of St. John and

St. Thomas. A medical postgraduate program of special interest to general internists and family practice physicians will be included. Write to Frank M. Woolsey, M.D., Dept. of Postgraduate Medicine, Albany Medical College, Albany, N.Y. 12208.

### Ophthalmologists to Meet In 1974 at Miami Beach

The American Society of Contemporary Ophthalmology will hold its 1974 meeting February 10 to 16 at the Fontainebleau Hotel, Miami Beach. The AMA has accredited numerous continuing education courses in all areas of ophthalmology. For full particulars write to Miss Virginia Kendall, A.S.C.O., 30 N. Michigan Ave., Room 1506, Chicago 60602. ◀

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## Indiana's New Medical Registration Law

The Board of Medical Registration and Examination of Indiana takes this opportunity to inform each person who holds a valid unrevoked certificate for a license to practice the healing arts in any form or manner granted by the Board of Medical Registration and Examination of Indiana that during the 1973 Legislature House Enrolled Act number 1305 pertaining to registration fees was enacted into law. The following is a verbatim copy:

### HOUSE ENROLLED ACT NO. 1305

AN ACT to amend IC 1971, 25-22-10-1 concerning professional licenses of the Board of Medical Registration and Examination as it relates to the annual reinstatement of fees.

*Be it enacted by the General Assembly of the State of Indiana:*

SECTION 1. IC 1971, 25-22-10-1 is amended to read as follows: Sec. 1. Every person who now holds, or may hereafter hold, a valid and unrevoked certificate for a license to practice the healing art in any form or manner, granted by either the state Board of Medical Registration and Examination

or by the Board of Medical Registration and Examination of Indiana, shall be required to register with the Board of Medical Registration and Examination of Indiana, in the form and manner determined by said board. Such registration shall be made annually, on or before August 31st of each year. Each applicant for registration shall submit with his application the sum of ten (\$10.00) dollars as the annual registration fee if he resides within the boundaries of the state of Indiana. All applicants residing outside the boundaries of the state of Indiana shall submit the sum of ten (\$10.00) dollars as the annual registration fee; provided, that no registration or fee for registration shall be required of any holder of a certificate on or before the month of July of the year following the year within which such certificate was issued. Failure of any such certificate holder to register and comply with the provisions of this chapter shall operate automatically to cancel his certificate, and any license issued thereunder and the continued practice after the cancellation of the certificate and license issued thereunder shall be considered as practicing without license. A certificate cancelled for failure to register may be reinstated by said board upon submission of the applicant's last registration certificate together with the current and delinquent fees and a penalty fee in the sum of fifty (\$50.00) dollars.

SECTION 2. Whereas an emergency exists for the immediate taking effect of this act, it shall be in full force and effect upon its passage.



# What's New?

\* \* \*

General Motors has two automobile safety seats for children, one an Infant Safety Carrier for babies up to 20 pounds and the other a Child Safety Seat for children between 20 and 40 pounds who can sit upright. Both seats have adjustable harnesses to restrain the child and are themselves secured to the car seats by standard automobile seat belts.

\* \* \*

Milton Roy Company is introducing a new line of home and hospital artificial kidney equipment. Modular construction is used wherever possible. It may be used either in the home or in hospital and is of a simplified design for ease of operation, training and maintenance.

\* \* \*

The Ames Company announces new MULTISTIX® Reagent Strips which now provide the broadest strip urine profile available. MULTISTIX measures pH, protein, glucose, ketones, bilirubin, blood and urobilinogen.

\* \* \*

McGraw-Hill announces the publication of a scientifically accurate, comprehensive, and readable consideration of the major factors which influence personal and community health. "Healthful Living" by Drs. Harold S. Diehl and Willard Dalrymple is now in its ninth revised, updated and expanded edition. \$12.95.

\* \* \*

The Kendall Company is introducing a new line of Curity Orthopedic Support Products designed for hospital use and also, where applicable, for patients to use after leaving the hospital. Curity Hard and Soft Cervical Collars, the Curity Pelvic Traction Belt, Rib Belts and Abdominal Binders are in the line.

\* \* \*

Welch Allyn now features a new illuminating source for their ophthalmoscope and otoscope. It provides twice the light intensity of conventional sources and has superior clarity, brilliance and intensity. The improvement is a miniature halogen lamp especially adapted for diagnostic instruments. In addition to all its obvious advantages the lamp has a longer life—from two to three times that of incandescent lamps.

\* \* \*

Medi-Facts announces a new, unique, multi-purpose credit-card-sized card called Medi-Facts to carry the information desirable in emergency care. Also useful for recording and announcing medical data for routine care. The hospital, clinic, or medical office will be able to generate an admitting form or visit sheet automatically.

\* \* \*

The University of California has published the proceedings of a symposium given in San Francisco in 1972 on sickle cell disease. "Sickle Cell Anemia: The Neglected Disease" is available at \$3 per copy. Write Dept. P, University Extension, U. of C., Berkeley, California 94720.

Specimen collections and output measurements are easily and accurately accomplished with the Specipan Collection Unit. Specipan, by Kendall, is a plastic pan shaped to fit in the front end of the lavatory to collect stool or urinary specimens. It is disposable and has a measurement gauge printed on the interior.

\* \* \*

"Help for the Handicapped Child" is published by McGraw-Hill. The book describes sources of help, both for the family financially and emotionally overwhelmed and for the family that can afford private medical care for a handicapped child. It will be helpful to physicians, teachers, social workers, ministers and others who make referrals. Price—\$7.95.

\* \* \*

American Hospital Supply announces the Tomac Single-Use Gas Anesthesia Circuit. It consists of two 39" corrugated breathing tubes preconnected to a "Y" connector, and a 3 liter latex rebreathing bag. It arrives sterile. Components of the circuit are conductive, and minimize gas absorption.

\* \* \*

LiquidCrystal, Inc. announces a new low-cost disposable oral clinical thermometer that utilizes a liquid crystal temperature sensor. The temperature level is indicated by a color-changing liquid crystal.

\* \* \*

The Health Department Corporation announces a new device for the detection of bleeding, parasites and other disorders of the intestine. A weighted gelatine capsule, when swallowed, leads a 140 cm length of nylon line into the upper GI tract. When the gelatine dissolves, the capsule separates after carrying the line into the duodenum. When the line is withdrawn the level of bleeding is indicated and parasites, such as Strongyloides and Giardia may be detected. Patient acceptance has been good.



"Happy Birthday."



## TAX TIPS

by LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

Here are two "one-liners" about the recent changes in the Indiana tax laws.

1. The corporate gross income tax will be eliminated over a period of 20 years.
2. Persons who rent their residences may deduct, for adjusted gross income tax purposes, one half the rent that they pay. For 1973, they may deduct up to a maximum of \$500 and, for 1974 and 1975, the maximum is \$1,000.

\* \* \*

The I.R.S. has issued a new check-list questionnaire which the Service urges taxpayers to use when incorporating a business and requesting an I.R.S. ruling concerning the transfer of assets to the corporation. See Rev. Proc. 73-10, 1973-17 IRB 37.

\* \* \*

The Nixon administration has proposed numerous important changes concerning qualified retirement plans. As expected, one proposal is to increase the income tax deduction allowable for contributions to H.R. 10 plans to the lesser of 15% of the taxpayer's net business income or \$7,500. This suggestion is made in order to eliminate the artificial incentive for the incorporation of professional practices. Ostensibly, this proposal is sound. However, even if the change is enacted, there will be many fairly common, situations in which self-employed persons will benefit more, income tax-wise, through the corporate structure than as sole-proprietors. One obvious example is where the sole-proprietor wants to contribute more than \$7,500 to the retirement plan. Another is where the taxpayer wants to contribute more than 15% of his net earnings to the retirement plan. Another proposal would allow self-employed persons to withdraw voluntary contributions without incurring the present severe penalties. Still another proposal would allow H.R. 10 plan contributions to be made as late as the due date for filing the income tax return and still be deductible for the year for which the return applies.

\* \* \*

Congress may go after the wealthy individual again, to insure that every group pays its fair share of income taxes, because studies indicate that Congress' last attempt was quite ineffective. For example,

statistics show that 276 people with incomes of more than \$100,000 paid no federal income tax for 1971. Of these persons, 72 had incomes in excess of \$200,000.

\* \* \*

The I.R.S. has now ruled that the cost of birth control pills, prescribed by a physician for a taxpayer, and the cost of a legal abortion or vasectomy are deductible for income tax purposes. See Rev. Rul. 73-200, 1973-15 IRB 24; Rev. Rul. 73-201, 1973-15 IRB 24.

\* \* \*

A recent revenue ruling that you should have your lawyer examine for you is Rev. Rul. 73-174. This ruling holds that even though an employee irrevocably assigns his rights in a group-term life insurance policy which is financed by his employer, the employee must include in his gross income the cost of the premiums that exceed the cost of \$50,000 of insurance, per I.R.C. section 79.

\* \* \*

Some of our readers will be happy (or sad) to know about Rev. Rul. 73-175. This states that if a divorced person remarries, then that person may utilize any support payments made by the **new spouse** in determining whether the support tests of I.R.C. §152 are met in order to claim an exemption for a child of the remarried person. Thus, more wives (rather than husbands) will be entitled to dependency exemptions than before. ◀

---

**Ruling that prohibited MDs from withdrawing voluntary contributions made to their Keogh plan prior to disability, or age 59½, will be revised, the IRS announced. Under its revised ruling, IRS will permit withdrawal of voluntary contributions made by an owner-employee prior to March 5, 1971. The previous ruling had been protested by the AMA.**



## From The Journal 50 Years Ago

The management of laryngeal diphtheria in outlying districts is much more difficult than in larger cities. The smaller communities do not have access to a modern contagious hospital with its trained staff of nurses and physicians, consequently the mortality is very high.

There are few physicians outside the contagious hospitals who have had any training in the art of intubation. This is one of the most difficult operations in surgery, as it requires a great deal of practice first upon the cadaver, then upon the living, under proper supervision. The only place this training can be received is in a few contagious hospitals, consequently the opportunities for learning are limited. Contagious hospitals should try to give this training to as many as possible. It is probably true that their mortality rate would be higher, but the common good demands that there be more physicians qualified to perform this operation.

In my experience in hospital and general practice the only lives that I really thought I had saved were by intubation. It is true that cases of pneumonia or typhoid fever sometimes recovered, but I always felt that it was through the grace of God that they recovered rather than as a result of my treatment. Intubation is really a spectacular operation. The child is usually in an extreme condition. Its lips and finger nails are blue. Its breathing has been loud and labored for several hours and it is almost exhausted. The parents realize the serious condition of the patient and are hysterical and of little help in the operation. The child is wrapped in a sheet, mummy fashion, the side mouth-gag introduced, and the proper size tube slipped into its larynx. This causes a paroxysm of hoarse coughing, some mucus is expelled, a little brandy helps in this, and then the child begins to breathe easier. Its color clears up almost immediately, and it is soon asleep.

The handicap resulting from the lack of proper hospital facilities in the smaller communities is a serious one and until it is removed, diphtheria will continue to take its toll among the precious lives of the children. . . . Byron N. Lingeman, M.D., Crawfordsville, "Laryngeal Diphtheria in the Smaller Communities," JISMA, August 1923.

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# impotence

due to androgenic deficiency in the American male.

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Methyltestosterone N.F. - 5 mg.

## Android<sup>®</sup> 10

Methyltestosterone N.F. - 10 mg.

## Android<sup>®</sup> 25

Methyltestosterone N.F. - 25 mg.

**DESCRIPTION:** Methyltestosterone is 17 $\beta$ -Hydroxy-17-Methylandrosta-4-en-3-one.

**ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone.

**INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

**PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

**CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

**WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. FBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued.

**ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

**DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.

INDICATION	Average Daily Dosage Tablets
In the male:	
Eunuchoidism and eunuchism	10 to 40 mg.
Male climacteric symptoms and impotence due to androgen deficiency	10 to 40 mg.
Postpubertal cryptorchidism	30 mg.

**HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

Write for Literature and Samples

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THE BROWN PHARMACEUTICAL CO., INC.  
2500 West 6th Street, Los Angeles, California 90057



## ART, HOBBY SHOW PLANNED FOR ISMA ANNUAL MEETING

Space will be provided at the 1973 annual meeting of the Indiana State Medical Association, October 8, 9 and 10 at Indianapolis, for an Art and Hobby Show.

Members of the ISMA and their wives are invited to participate. Information regarding this year's show may be obtained from:

Indiana State Medical Association	or	Mrs. Harry Siderys
3935 North Meridian Street		9015 Kirkham Court
Indianapolis 46202		Indianapolis 46260

It will be the responsibility of each exhibitor to see that his work gets to and from the new Indiana Convention-Exposition Center, 100 S. Capitol Avenue, Indianapolis. (The final arrangements will be provided by the committee.)

ISMA will provide suitable display facilities, but each exhibitor is responsible for transportation costs or any other such expenses involved in entering his exhibit.

In order that the committee may do its best in fulfilling the needs of your exhibit, it is **ESSENTIAL** that you accurately indicate below the amount of space required for your exhibit.

ALL exhibits must be labeled with your name and address and each should be titled.

We do not encourage rare or valuable exhibits since their safety cannot be insured.

In order that the committee may be adequately prepared for your exhibit, **ALL** applications must be submitted no later than **SEPTEMBER 29, 1973**.

We solicit your exhibit to make this year's show the most successful.

---

### APPLICATION for SPACE in ART and HOBBY SHOW

Exhibitor \_\_\_\_\_ Total number items to be exhibited \_\_\_\_\_

Address \_\_\_\_\_

Telephone No. \_\_\_\_\_

CATEGORY*	TITLE	SIZE or SPACE REQUIRED
-----------	-------	------------------------

_____	_____	_____
_____	_____	_____
_____	_____	_____

We also need several people to accompany the exhibit for short periods of time during the convention; if you can help, please indicate below, and a member of the committee will contact you to arrange a convenient time period for you.

YES \_\_\_\_\_ NO \_\_\_\_\_

MAIL TO:

Mrs. Harry Siderys  
9015 Kirkham Court  
Indianapolis, Indiana 46260

DEADLINE for submission  
of application is:  
**SEPTEMBER 29, 1973**

\*Please indicate whether your exhibit is oil, watercolor, photography, sculpture, or arts and crafts, etc.



# New Members, Additions to ISMA Roster

## CASS COUNTY

John W. Durkin, M.D.  
Howard Clinic  
Logansport 46947

## ALLEN COUNTY

Robert Furtado, M.D.  
3030 Lake Ave.  
Fort Wayne 46805  
  
Philip Shriner, M.D.  
3030 Lake Ave.  
Fort Wayne 46805

Michael L. McArdle, M.D.  
2609 Fairfield Ave.  
Fort Wayne 46807

## HAMILTON COUNTY

Richard G. Bilodeau, M.D.  
R.R. #6, Box 400  
Noblesville 46060

## JEFFERSON-SWITZERLAND COUNTY

Thomas D. Breitweiser, M.D.  
122 Fairmount Drive  
Madison 47250

## LAKE COUNTY

William M. Hamby, M.D.  
5231 Hohman Ave. #628  
Hammond 46320

## LaPORTE COUNTY

James W. Jenson, M.D.  
1511 Wabash  
Michigan City 46360

## MARION COUNTY

Richard E. Wurster, M.D.  
5506 East 16th Street  
Indianapolis 46218

Veronica Mackenzie, M.D.  
3266 North Meridian St.  
Indianapolis 46208

Robert G. Reed, M.D.  
1303 North Arlington Ave. IM CD  
Indianapolis 46219

William M. Stone, M.D.  
5010 East 68th Street Ob-Gyn  
Indianapolis 46220 Resident

Natwerlal S. Jani, M.D.  
Health & Hospital Corp. Public  
City-Co. Building #1841 Health  
Indianapolis 46204

Robert M. Hurwitz, M.D.  
8734 Old Town Lane D  
Indianapolis 46260

Samuel Dennis Hennessee, M.D.  
458 Ash Drive ANES  
Carmel 46032

Larry G. Hitchcock, M.D.  
3743 Ashway Drive  
Indianapolis 46224

Milton R. Carlson, M.D.  
12415 Brookshire Pkwy. ORS  
Carmel 46032

Robert A. Blackburn, M.D.  
2617 Cardigan Road ENT  
Indianapolis 46268

Bruce H. Bender, M.D.  
2154 Stoneham Dr. IM  
Indianapolis 46260

James E. Cassady, M.D.  
1734 Pemberton Lane IM  
Indianapolis 46260

## ST. JOSEPH COUNTY

Thomas P. Dunfee, M.D.  
912 East La Salle St.  
South Bend 46617

Rafael Macias, M.D.  
2208 Am. Natl Bank Bldg.  
South Bend 46601

Gary A. Mitchell, M.D.  
912 East La Salle St.  
South Bend 46617

## STEUBEN COUNTY

Richard G. Spindler, M.D.  
301 East Maumee  
Angola 46703

## VANDERBURGH COUNTY

Thomas Harmon, M.D.  
516 Oriole Drive  
Evansville 47715

R. Anthony Marrese, M.D.  
611 Harriet  
Evansville 47710

## Errata

The Journal regrets any embarrassment caused by errors which appeared in the Roster in the June issue, as follows:

The names of the following full-dues paying members were inadvertently omitted:  
Saverio Caputi, Jr. (R), 534 Turtle Creek Drive, #C2, Indianapolis 46227  
(Marion Co.)

Richard H. Miller (GS), 511 W. Wayne St., Fort Wayne 46802 (Allen Co.)  
Harold George Petitjean (GP), R.R. 2, Haubstadt 47639 (Gibson Co.)

The medical specialty of the following physicians was incorrectly listed; the correct specialty designation follows the physician's name and address below:

Herman F. Rusche, 3700 Bellemeade, Evansville 47715: Gastroenterology  
John M. Wambo, 920 Whitewater Blvd., Richmond 47374: Obstetrics and Gynecology

The address of Dr. G. M. Maldia (IM) should be: 3030 Lake Ave., Fort Wayne 46805.

# *Annual Meeting Dates of Professional Medical and Allied Organizations*

## **AMERICAN MEDICAL ASSOCIATION ANNUAL CONVENTION**

**Date** Dec. 1-5, 1973  
**Place** Anaheim, Calif.

## **NORTHERN INDIANA PSYCHIATRIC SOCIETY**

**Date** Fourth Wednesday of every  
month, September through June  
**Place** For location and program, inquire  
Jon Leipold, M.D.,  
919 E. Jefferson Blvd.  
South Bend 46622

## **INDIANA STATE MEDICAL ASSOCIATION CONVENTION**

**Date** October 6-11, 1973  
**Place** Indianapolis Convention-  
Exposition Center

## **INDIANA ACADEMY OF FAMILY PHYSICIANS**

**Date** April 2-4, 1974  
**Place** Stouffer's Indianapolis Inn

## **INDIANA PSYCHIATRIC SOCIETY**

**Date** Second Wednesday of September,  
November, January, February,  
March and April  
**Place** For time and place, inquire Wes-  
ley A. Kissel, M.D., 1815 N.  
Capitol Ave., Indianapolis 46202

## **INDIANA SOCIETY OF INTERNAL MEDICINE AND AMERICAN COLLEGE OF PHYSICIANS**

**Date** October 10, 1973  
**Place** Indianapolis Convention-Exposi-  
tion Center

## **INDIANA CHAPTER, AMERICAN ACADEMY OF PEDIATRICS**

**Date** Sept. 26-27, 1973  
**Place** Ramada Inn, Nashville

## **INDIANA ASSOCIATION OF PATHOLOGISTS**

**Date** December 1, 1973  
**Place** Indianapolis

## **INDIANA STATE NURSES ASS'N**

**Date** October 11-13, 1973  
**Place** French Lick

## **INTERNATIONAL COLLEGE OF SURGEONS**

**Date** December 1, 1973  
**Place** Indianapolis

## **INDIANA LUNG ASSOCIATION**

**Date** May 7-8, 1974  
**Place** Indianapolis

## **INDIANA THORACIC SOCIETY**

**Date** May 7-8, 1974  
**Place** Indianapolis

## **INDIANA STATE PODIATRY ASS'N**

**Date** Oct. 11-14, 1973  
**Place** Ramada Inn, Nashville

## **INDIANA PHILIPPINE MEDICAL ASS'N**

**Date** Sept. 2, 1973  
**Place** Portage



# What's New?

Searle has a new line of urinary endocrine test controls. TEKIT® Broad Spectrum Urine Control and Special Endocrine Urine Control are packaged for laboratory efficiency and convenience.

\* \* \*

USV Pharmaceutical announces that it has received FDA marketing approval for the new anti-obesity drug, Voranil. It is a totally new drug entity which originated with Ciba-Geigy. Marketing will commence immediately.

\* \* \*

Robins is introducing Pondimin®, a product offered for the management of exogenous obesity as a short-term adjunct in a regimen of weight reduction based on caloric restriction. Information brochures will outline detailed information on the drug.

\* \* \*

Vivonex is now prepared by Eaton Laboratories in an unflavored form. The new form, which may be mixed to suit the patient's preference, will be made in both the Standard Diet and the High Nitrogen Diet. The six flavored forms, orange, vanilla, grape, chocolate, strawberry and beef broth, will be continued.

\* \* \*

Upjohn announces a new product, Methosarb (calusterone), a synthetic steroid related to testosterone, which is recommended only for the palliative therapy of advanced inoperable or metastatic carcinoma of the breast in postmenopausal women when hormonal therapy is indicated. Methosarb is supplied in the form of 50 mg tablets.

\* \* \*

Behavioral Publications has published three books on drug abuse. "Major Modalities in the Treatment of Drug Abuse," edited by Leon Brill, is listed at \$12.95. "The Yearbook of Drug Abuse," edited by Leon Brill, is sold for \$19.95. "Methadone: Experiences and Issues," edited by Carl D. Chambers, is listed at \$19.95.

\* \* \*

Kendall announces a new undercast padding and a new plaster bandage. New Webril® orthopedic bandage has soft ripples that make the bandage super comfortable. Castmate® plaster bandage has a very low setting temperature and is super strong.

\* \* \*

A new McGraw-Hill book, released on May 31, is "VD: The Silent Epidemic." Written by Margaret Hyde to answer many questions about venereal disease, especially for teenagers. Public health surveys indicate that lack of knowledge is the major factor in the present VD epidemic. It sells for \$4.33 to libraries and for \$4.50 to the trade and teens.

\* \* \*

"Blueprint for a Brighter Child" by Brandon Sparkman and Ann Carmichael has just been published by McGraw-Hill (Price \$5.95). School readiness is de-

veloped from birth up to entrance into school. A great deal depends on the conditioning which the child receives in the first few years before school. How to do this is outlined for parents in this book.

\* \* \*

Behavioral Publications has just released "Critical Incidents in Child Care: A Case Book" the first comprehensive case book for child care workers. It is edited by Jerome Beker of the Institute for Child Mental Health. Price: \$7.95 soft, \$15.95 hard.

\* \* \*

American Hospital Supply has a new footprinter for babies called "Tomac® Kleen-Print Footprinter." No ink touches the mother, infant or user. No blotting, no ink and roller, no mess, no need to wash afterwards. The footprinter may be placed over any standard identification form. Prints are made directly through the footprinter onto the form.

\* \* \*

McGraw-Hill has released **Hilary**, a story of the courageous adaptation of a young girl who, almost totally incapacitated by myasthenia gravis, has been able to learn to communicate by means of special devices. With only the ability to feel and hear and with slight movement of one toe she operates an electric typewriter, enjoys "talking" to friends, writes poetry, listens to music and thoroughly enjoys life—an inspiration to all other handicapped people.

\* \* \*

Parke-Davis is marketing a new oral contraceptive. The product, called Loestrin 1/20, has 60% less estrogen than any currently marketed combination product.

\* \* \*

Random House announces the publication of the autobiography of Dr. Howard A. Rusk, who, as an Air Force physician and head of the New York University Institute for Rehabilitation, helped form rehabilitation medicine and develop it as a science. "A World to Care For" sells for \$7.95.

\* \* \*



We could sleep at the foot of the bed?

# County, District News

## Eighth District

Meeting date has been changed to August 29, Green Hills Country Club, Muncie.

## Tenth District

Meeting date has been changed to September 5, Lakes of the Four Seasons Country Club, Valparaiso.

## Eleventh District

Meeting date has been changed from September 19 to October 3, Meshingomesia Country Club and Emley's Restaurant, Marion.

## Dearborn-Ohio

Dr. William Duffy of Cincinnati, Ohio, spoke on nuclear medicine to members of the Dearborn-Ohio County Medical Society at their May meeting. Dr. Howard Jackson, Fourth District Trustee, was a guest.

## Elkhart

Dr. Barry S. Schiffrin of the Harvard Medical School and Beth Israel Hospital, Boston, was the speaker at the May meeting of the Elkhart County Medical Society. "Obstetrics on the Horizon" was his topic.

## Hancock

Thirty-eight members and guests were present for the April meeting of the Hancock County Medical Society. Dr. George Belshaw, Indianapolis obstetrician, was the speaker at the evening program. He spoke on laparoscopic tubal cauterization and the treatment of vaginitis and lesions of the vulva.

The Hancock County Cancer Society sponsored the May meeting of the Society and the speakers were Drs. Dyke and Sweeney from the Eli Lilly Company. Their topic was "What's New in Cancer Research?"

## Rush

Members of the Rush County Medical Society and the Medical Auxiliary jointly participated in festivities May 20 honoring the Indianapolis physicians who handle family practice at the Rush Memorial Hospital on Friday nights and Saturdays. A social afternoon was enjoyed at the country home of Dr. and Mrs. Frank Green, followed by dinner at the Durbin Hotel.

Dr. A. Alan Fischer, director of the Family Practice Program at the I.U. Medical School, spoke briefly, as did Dr. Harry McKee, Society president, and Dr. Wyndam Nutter, who spoke on behalf of the Hospitals' chief of staff.

## Wayne-Union

Drs. Paul Rhoads, Glen Ramsdell and Arthur Millis presented a program titled "An Evening with Sir William Osler and Rene Laennec" at the May meeting of the Wayne-Union County Medical Society. Forty-two members were present.

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A number of county and district societies have elected officers, as follows:

## Seventh District

President, Dr. Eric Clark, Plainfield; president-elect, Dr. Ray D. Miller, Martinsville; secretary, Dr. Malcolm O. Scamahorn, Pittsboro.

## Ninth District

President, Milton W. Erdel, Frankfort; secretary, Harry T. Stout, Frankfort.

## Huntington

President, Dr. Richard Wagner; vice president, Dr. Richard Blair; secretary-treasurer, Dr. Howard Marks, all of Huntington. Dr. Wagner will serve as delegate and Dr. Paul Doermann as alternate delegate.

## Jay

President, Dr. George Donnally, Geneva; secretary, Dr. Amin T. Nasr, Portland. Dr. James S. Fitzpatrick will serve as delegate to the ISMA annual meeting.

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## Indiana Medical Foundation

The Indiana Medical Foundation was organized to furnish support for the educational activities of the Indiana State Medical Association. These activities include programs for continuing education and the scientific publications of The Journal. Contributions made to the foundation are deductible by donors in accordance with the Internal Revenue Code. Bequests, legacies and gifts are deductible for federal estate and gift tax purposes. Memorial contributions made to the foundation will be formally recorded and acknowledgment will be sent to the family. Gifts, bequests, and memorial contributions may be mailed to the foundation at 3935 N. Meridian St., Indianapolis 46208.



# Deaths

## Richard Artz, M.D.

Dr. Richard Artz, 56, Angola surgeon, died May 26 at Cameron Hospital following a long illness.

He received his M.D. degree from the Columbia College of Physicians and Surgeons in 1943 and interned at Flower and Fifth Avenue hospitals in New York City. He served as a Captain in the Army Medical Corps in the European Theatre from 1944 to 1946. After the war he was a graduate student in Surgery at New York Medical College and served as chief thoracic surgeon at the Metropolitan Hospital, New York City, from 1950 until he came to Angola in 1953.

Dr. Artz was a Fellow of the American College of Surgeons and was a former member of the Steuben County Medical Society and the American Medical Association.

## Jess E. Burks, M.D.

Dr. Jess E. Burks, 53, former Crawfordsville physician, died April 25 at Kirkwood, Mo., where he resided. He practiced at Crawfordsville from 1947 until the mid-1960s when he accepted a position as physician for General Motors Corporation at St. Louis.

He was a graduate of the Indiana University School of Medicine and served in the Army Air Force in World War II. He was a former member of the Montgomery County Medical Society.

## N. Cort Davidson, M.D.

Dr. N. Cort Davidson, 71, Indianapolis, died June 8 in Winona Memorial Hospital.

Dr. Davidson, a 1928 graduate of the Indiana University School of Medicine, had been a general practitioner 44 years and was in practice at the time of his death.

He had interned at Indianapolis General Hospital and was a member of the American Medical Association, the Marion County Medical Society, and the Indiana Academy of Family Practice.

In 1972 he became a Senior Member of the Indiana State Medical Association.

## William R. Goodrum, M.D.

Dr. William R. Goodrum, 53, of

Cayuga, a retired physician and surgeon, died July 1.

He had practiced medicine at Elkhart from 1945 to 1949 when he entered the U. S. Army and served in Korea.

Dr. Goodrum was a graduate of the University of Illinois Medical School and interned at Memorial Hospital, South Bend. He served a residency at the New York City Cancer Institute in 1949 and 1950.

He was a former member of the Elkhart and Parke-Vermillion County Medical Societies.

## Harry R. Kerr, M.D.

Dr. Harry R. Kerr, 76, Indianapolis, died June 25 in Methodist Hospital. He retired in 1965 after practicing medicine at 2817 E. Washington St. from 1923 to 1965.

Dr. Kerr was graduated from the Indiana University School of Medicine in 1922 after service with the Army in World War I.

A past president of the medical staff at Methodist Hospital, Dr. Kerr was a member of the American Medical Association and the Marion County Medical Society; he was a Senior Member of the Indiana State Medical Society.

## Hedwig S. Kuhn, M.D.

Dr. Hedwig S. Kuhn died June 17 at Munster. She was 78.

Widely recognized as an expert on industrial eye medicine, Dr. Kuhn and her late husband, Dr. Hugh A. Kuhn, founded the Kuhn Clinic, which merged with the Hammond Clinic in 1965. She was a graduate of the Rush Medical College in 1919 and interned in Ohio, returning to the Calumet Region in 1921.

Instrumental in the development of safety glasses in industry, Dr. Kuhn was concerned about safety in other areas and was recognized for her work by appointment in 1957 to President Eisenhower's Traffic Safety Commission. She also served on a presidential subcommittee concerned with employing the physically handicapped and the Congressional Committee for Health and Welfare.

In 1970 she received the highest award given by the National Safety Council—the "Distinguished Service to Safety Award for 1970"—and was inducted into the ISMA 50-Year Club. She was also a member of the American Medical As-

sociation and the Lake County Medical Society.

## Harry Howard Slominski, M.D.

Dr. Harry H. Slominski, 83, one of South Bend's oldest practicing physicians and a U.S. Navy veteran of both World Wars, died June 16 in Bemidji, Minn., while on a fishing trip.

He had practiced medicine since his graduation from Northwestern University Medical School in 1914 and practiced at South Bend from 1945 until his death. He was a member of the staff of St. Joseph's and Memorial Hospitals, the American Medical Association, the Indiana Academy of Family Physicians, the St. Joseph County Medical Society, and was a Senior Member of the Indiana State Medical Association.

Dr. Slominski served as a U.S. Navy lieutenant on a troop ship from 1917 to 1920 and aboard the aircraft carrier Saratoga from 1941 to 1944. He retired as a commander in the Naval Reserve in 1950.

## Frank T. Tyler, M.D.

Dr. Frank T. Tyler, 92, who practiced medicine in New Albany until he was 91 years old, died June 20 at Floyd County Memorial Hospital.

He was a member of the last graduating class at the old Kentucky School of Medicine, the forerunner of the University of Louisville School of Medicine, in 1908. Dr. Tyler had an office at Crandell for four years, moving to New Albany in 1912.

During his later years Dr. Tyler confined his activities to general practice but early in his career he was very active as a surgeon.

A member of the American Medical Association and the Floyd County Medical Society, Dr. Tyler was a Senior Member of the ISMA and became a member of its 50-Year Club in 1958.

## Paul F. Zwerner, M.D.

Dr. Paul F. Zwerner, 62, Terre Haute, died May 12.

A 1934 graduate of the Indiana University Medical School, he interned at Peoples Hospital, Akron, Ohio. Dr. Zwerner served in the Air Force in World War II.

He was president of the Vigo County Medical Society in 1961 and was a former member of the Indiana State Medical Association. He was also a member of the American Academy of Family physicians. ◀

# Association News

## BOARD OF TRUSTEES

May 20, 1973

The Board of Trustees was called to order at 9:00 a.m. on Sunday, May 20, in the Headquarters Building of the Association by Chairman Gilbert Wilhelmus.

Roll Call showed the following:

District	Trustee	
1	Gilbert Wilhelmus, Chairman	Present
2	Paul W. Holtzman	Absent
3	Eli Goodman	Present
4	Howard C. Jackson	Present
5	Cleon Schauwecker	Present
6	Paul Inlow	Present
7	John O. Butler	Present
7	Joseph Ferrara	Present
8	Richard Ingram	Present
9	William Sholty	Present
10	Vincent J. Santare	Present
11	James A. Harshman	Present
12	William R. Clark	Present
13	G. Beach Gattman	Present

District	Alternate	
1	Raymond Newnum	Absent
2	Betty J. Dukes	Absent
3	Thomas A. Neathamer	Absent
4	William F. Blaisdell	Present
5	William G. Bannon	Present
6	Glen Ward Lee	Present
7	Donald C. McCallum	Present
7	John G. Pantzer	Absent
8	Jack L. Alexander	Absent
9	Max Hoffman	Absent
10	Martin O'Neill	Present
11	Lloyd L. Hill	Present
12	Walter D. Greist	Absent
13	Donald S. Chamberlain	Present

Officers:		
James H. Gosman	Present	
Joe Dukes	Present	
Arvine G. Popplewell	Absent	
Hugh K. Thatcher, Jr.	Present	
Frank B. Ramsey	Present	

Executive Committee:		
Donald M. Kerr	Absent	
Vincent Santare	Present	

AMA Delegates and Alternates:		
James A. Harshman	Present	
Eugene Senseny	Absent	
Malcolm Scamahorn	Present	
Lowell H. Steen	Absent	
Jack E. Shields	Absent	

A. Alan Fischer	Absent
Ross L. Egger	Present
Kenneth O. Neumann	Present
Thomas Tyrrell	Absent
P.J.V. Corcoran	Absent

Guests:		
John W. Beeler	Absent	
John O. Butler	Present	
Dwight W. Schuster	Present	
Maurice Glock	Present	
Peter Gutierrez	Present	
Wilbert McIntosh	Present	
John G. Suelzer	Present	
B. T. Maxam	Absent	
Merrill Weseman	Present	
Joe Black	Present	
Wm. Dudley, Heart Foundation	Present	
Lee Mortenson, AMA,	Present	

Staff:		
Robert Amick	Present	
Howard Grindstaff	Present	
John Walters	Present	
Michael McDermott	Present	
Kenneth W. Bush	Present	
Jas. A. Waggener	Present	

**Treasurer's Report**  
DR. HUGH K. THATCHER, JR., TREASURER, gave a detailed report of the association's various accounts and funds, which was approved on motion by Dr. Thatcher and a second by Dr. Harshman.

**Building Committee Report**  
Dr. Thatcher, chairman of the Building Committee, then made a report concerning the study being made by his committee. He pointed out that the existing property had increased tremendously in value, however, the present building is so constructed that an addition could not be made unless a skeleton was prepared over the existing building for putting additional stories on the present structure. This would necessitate of course the expansion of the area by building on a wing at the back of the building and taking part of the area of the properties on Pennsylvania Street for additional parking. He proposed also that there was some thought being given to selling the existing property and relocating the building in another area.

Dr. Thatcher suggested that the committee be empowered to employ an architect to plan for additional space at the present headquarters and have a qualified realtor assess the present property and explore the possibility of relocation.

On a motion by Dr. Harshman seconded by Dr. Ferrara, the committee was given permission to explore all options available.

**Report of The Journal Editor**  
Dr. Ramsey, editor of *The Journal* announced an increase in price of paper, stating of course this would be reflected in the cost of publishing *The Journal*.

**Discussion with Representatives on the Blue Shield Board**  
Drs. Beeler, Butler, Schuster, Glock, Gutierrez and McIntosh were invited to meet with the Board of Trustees for a discussion of some of the major policies established by the Ad Hoc Committee on Relationships of Blue Shield. One of the primary issues for discussion was the question of expansion of the existing Blue Shield Board by adding three additional consumer members. It was pointed out that the Ad Hoc Committee had previously recommended no further expansion of the Board.

A free and open discussion then took place concerning this question with the suggestion being made that the purpose could be accomplished by establishing an advisory committee to the Blue Shield Board. It was also suggested by Doctor Black, Chairman of the Blue Shield Board, that greater interplay between the ISMA Board and that of Blue Shield should occur and that they schedule quarterly meetings.

On motion of Dr. Ferrara seconded by Dr. Gosman, it was moved that copies of the Board minutes dealing with Blue Shield matters be sent as of this date to every physician member of the Board. The motion was carried.

Dr. Harshman moved to reconsider by proposing an amendment to the original motion that the minutes pertaining to Blue Cross-Blue Shield matters be sent also to physician members of the Blue Cross Board. This was seconded by Dr. Schauwecker and carried and the original motion as amended was adopted.

Dr. Ferrara then moved that the ISMA Board recommend that the Blue Shield not increase the Blue Shield Board at this time and advise Blue Shield Board to pursue the idea of using advisory committees.

The chair pointed out that the April 15th meeting of the Board had moved to maintain the present number of members on the Blue Shield Board.

Dr. Ferrara asked again that, in addition to the action of April 15, that we include that "the ISMA Board of Trustees recommends to the Blue Shield



Board that they pursue the idea of using advisory members so as to establish specific directives." The motion was then seconded by Dr. Gosman, put to vote and carried.

Additional coverage by Blue Cross-Blue Shield. Dr. Black stated that Blue Shield was working with surgi-centers to lower costs and hoped that by October there would be a report on plans for more coverage for outpatient and in-office services. Dr. Black also pointed out that, in the case of abortions, payment has been denied for abortions on demand, the same as for plastic surgery. However, now that the abortion law has passed, this will have to be re-evaluated.

CHAIRMAN: We will now discuss the minutes of the April 14 and 15 meeting. If there are no objections we will accept them as printed. There being no objections, the minutes were approved.

**President's Report:**

Dr. Gosman discussed his itinerary since the last meeting of the Board and recommended that each member of the Board become a sustaining member of AMPAC by paying a total of \$99.00. Following a discussion of this, it was moved by Dr. Goodman, seconded by Dr. Schauwecker, that this be recommended to the Board as highly desirable. The motion was put to a vote and carried.

He next discussed the concept of PSRO and reviewed several of the matters to come before the convention in October.

Reporting on the Retreat, the president pointed out there had been a recommendation made for organizing an Assessment Committee with a task force to be sent to those communities seeking a physician. The task force would go into the community to investigate the specific needs as to what the community has to offer and make this information available to prospective physicians. By consent, this suggestion was referred to the Commission on Special Activities and to their Committee on Rural Health for study and possible implementation.

Dr. Gosman went ahead to discuss the fact that Washington has finally decided to finance a study on propranolol in the treatment of heroin addiction.

He again recommended that statewide toll-free lines be installed for the Tel-Med program.

He requested that Board members supply him with the names of five delegates from their respective districts which he might use in naming his reference committees.

He then discussed the feasibility of having a meeting of the delegates in September for the purpose of discussing the implications of PSRO. This would be a meeting strictly for discussion and information and not one for action. An extensive discussion followed this suggestion and Dr. Goodman moved to have a one-day meeting of the general membership, for information only, at no cost to the Association, in September. The motion died for lack of a second. Dr. Gosman's original suggestion to have a House of Delegates' meeting in September for information only was then put to a vote but did not carry.

Dr. Ingram then moved that PSRO factual information (not opinions) be disseminated to county medical society officers and delegates prior to the October meeting. The motion was seconded by Dr. Harshman and amended by Dr. Schauwecker to include trustees in the mailing. The motion was further amended by Dr. Ferrara to include anyone intensely interested. The motion, as amended, was put to a vote and carried.

**Report of President Elect:**

Dr. Dukes' comments were primarily involved with the recent activities of the Food and Drug Administration regarding the withdrawal of several drugs from the market. He pointed out that there will be some information coming out in THE JOURNAL and urged every physician to be responsive to some of the suggestions which will be made.

The Board then recessed for lunch.

CHAIRMAN WILHELMUS: The first order of business this afternoon will be to have the reports of the trustees.

DISTRICT 1: DR. WILHELMUS reported that the First District will be having their meeting this coming Thursday. Dr. Otis Bowen will be the speaker.

DISTRICT 2: No report.

DISTRICT 3: No report.

DISTRICT 4: Dr. Jackson moved remission of dues for a physician from the Bartholomew-Brown Medical Society. The motion was put to a vote and carried.

DR. JACKSON: I have also a letter from Dr. Jack Shields stating he believes some action should be taken concerning the constitutionality of Phase II, Phase III, Medicaid, Medicare, HMO and PSRO and he has a proposed resolution to be presented by this Association to the AMA House of Delegates.

CHAIRMAN WILHELMUS: At the last Board meeting he presented this and it was referred back to him for a fiscal note; therefore, no action was taken in

regard to approval from the Board.

DR. HARSHMAN: We have already passed the deadline for resolutions to be submitted. The only way we could submit a resolution now at this late date would be if it is of an emergency nature and I don't believe this would qualify as an emergency resolution.

DISTRICT 5: DR. SCHAUWECKER: Our district meeting will be this coming Wednesday, May 23, at 4:00 p.m. The first order will be a business meeting and we are having a fine speaker for the event. We would like as many of the trustees as possible to join us for this meeting.

DISTRICT 6: DR. INLOW reported that the meeting was held the early part of May and he was re-elected trustee for the Sixth District.

DISTRICT 7: DR. FERRARA: The Seventh District meeting will be held on June 20 at the Speedway Motel.

DISTRICT 8: DR. INGRAM: Jack Benny is going to be the speaker at our meeting and the tab is \$30 per person.

DISTRICT 9: DR. SHOLTY: Our meeting will be held June 14 and we plan to have one of the astronauts as one of the speakers for this meeting.

DISTRICT 10: DR. SANTARE: The Tenth District meeting has been changed from May 30 to September 5. It will be held at the same location.

DISTRICT 11: No report.

DISTRICT 12: No report.

DISTRICT 13: No report.

CHAIRMAN WILHELMUS: We will now hear from Dr. John Suelzer, chairman of the Commission on Emergency Medical Services.

DR. SUELZER proceeded to explain the activities of the Commission with regard to the emergency medical service and the failures of the legislature to adopt legislation in this area. He distributed to the Board the standards which had been developed by the Commission in consultation with other interested groups. He requested the Board's approval of these points, stating that he had an audience with the Governor at 3:00 p.m. this coming Friday at which time they will present these standards to the Governor and request that he call a Governor's Conference for the purpose of attempting to create enough interest to have a bill passed in the forthcoming session of the legislature.

It was moved by Dr. Goodman, seconded by several, for the Board to approve the standards as set forth by the Commission. This was put to a vote and carried.



CHAIRMAN WILHELMUS: I think the commission has done an excellent piece of work. It is a shame that something like this could not have been accomplished several years ago.

CHAIRMAN WILHELMUS: We will now have a report from Dr. Harshman, the Board liaison representative with Blue Cross.

DR. HARSHMAN reported that an evaluation process was being conducted in regard to in-office procedures. It is planned to submit a list of these procedures to the Medical Advisory Committee in an attempt to get them approved and also to obtain approval for reimbursement for outpatient surgery. He detected a definite commitment on the part of the Blue Cross-Blue Shield people to get the job done and, while it is a slow process, it is hoped that a schedule will be available for the Board's review shortly after the 21st of June.

CHAIRMAN WILHELMUS: We will now hear from Dr. Goodman, chairman of the Board Committee on Economic and Fiscal Matters.

DR. GOODMAN: Our committee has been meeting off and on all through the morning and at lunch for discussions concerning the request from the Commission on Public Information for a substantial amount of money to conduct an accelerated PR program. We have discussed this with the treasurer and we find it might be possible to extract \$2,000 in addition to their initial funding of \$2,000—to be taken from the educational account and the budget. We are aware that any additional funds will have to come about from a properly prepared budget presented from this Board to the House. I therefore would move, and I do this primarily due to the enthusiasm that has been demonstrated by the commission, that the Board allocate an additional \$2,000 to the Commission on Public Information. This motion was seconded by Dr. Gosman, put to a vote and carried.

CHAIRMAN WILHELMUS: We will now hear from Dr. Ferrara, chairman of the Ad Hoc Committee to Work with Health Careers.

DR. FERRARA: The only report I have to make is that the Indiana Health Careers met about two weeks ago and out of curiosity I attended the meeting. I am very much impressed with what they are doing and would like to suggest that the Board and the Association continue to back the Indiana Health Careers in their endeavors. As I get more information I would like to report again to the Board at a later time.

CHAIRMAN WILHELMUS: We will now have a report from Dr. Inlow, chairman of the Ad Hoc Committee to Study Streamlining the Annual Convention.

DR. INLOW made several suggestions, among them that more time be allowed for playing golf and, if necessary, to extend the convention for a full week.

DR. GOSMAN: I would like to ask Dr. Inlow if he could appear before the Commission on Convention Arrangements to explain his feelings.

DR. CLARK raised the question as to whether any plans have been made for recognition of the chairmen of the commissions and committees.

CHAIRMAN WILHELMUS: We now take up the matters referred from the Executive Committee.

MR. WAGGENER: We have one item from the Executive Committee concerning the activities of the Retail Credit Bureau in procuring a patient's medical information. The way it was explained to me is that some insurance carriers feel that physicians' offices are slow in filling out insurance forms, plus some physicians want to make a charge for this, and insurance companies state they are experiencing difficulty in gathering this information on applicants for insurance. This matter was called to my attention by a physician in Crawfordsville who sent to me a copy of the information form and I, in turn, contacted the Indianapolis office of the Retail Credit Bureau and found that they are doing this nationwide.

Further, I checked with the American Medical Association and they were not aware of this activity. According to the form, they have a release from the applicant for insurance which permits them to obtain copies of medical records from the applicant's personal physician. A copy of this information is then sent to the insurance company and they claim they keep a copy in their so-called "privileged file" for a period of 90 days and then it is destroyed.

I informed the physician I would bring this up for discussion to see if there was any feeling on the part of the Executive Committee one way or another and they in turn have referred the question to this Board.

Further, the Retail Credit Bureau contends that physicians like this program. I asked them what they paid for this information and they quoted all the way from \$3 to \$10. I also got the impression that many times they did not pay the physician at all.

The matter was then discussed by Drs. Gosman, Ingram, Jackson, Harshman and others. Dr. Harshman then moved that we not approve of this program and so inform our membership by putting this information in the Newsletter. The motion was seconded by Dr. Santare, put to a vote and carried.

CHAIRMAN WILHELMUS: Next we will move to the unfinished business. We have a motion on the table.

Item A. Tabled motion by Dr. Chamberlain concerning PSRO. It was moved by Dr. Santare, seconded by Dr. Gosman to continue to let this item lay on the table.

Item B. Dr. Ingram's motion which was tabled at the last meeting. Dr. Clark moved to continue the table. It was moved by Dr. Goodman to reconsider the motion, was put to a vote and failed.

Item C. Tabled motion by Dr. Thatcher at the last meeting. There being no motion made to resume consideration, the action was left on the table.

CHAIRMAN WILHELMUS: Now for the report of the AMA Trustee Dr. Wood. The report will be made by Dr. Gosman in the absence of Dr. Wood.

DR. GOSMAN read a report prepared by Dr. Wood which was taken as a matter of information.

A copy of the AMA long-range planning report (Battelle-Columbus) was duplicated and distributed to the Board. This was also taken for information.

CHAIRMAN WILHELMUS: The next item is the minutes of the meetings held on April 14 and 15. If there are no corrections or objections, we will approve them as written. Hearing no objections, they were approved.

DR. CHAMBERLAIN then requested that the headquarters office compile a directory containing the name, address, and phone number of each commission member, trustee, alternate trustee, district officers, and officers of the state organization as well as the county medical society officers, in such a manner so that each district would have its own page. Dr. Santare moved that this be done, seconded by Dr. Gattman, put to a vote and carried.

The Board then went into executive session.

DR. SANTARE: Has the date for the next meeting been established?

CHAIRMAN WILHELMUS: With your approval, we will have a one-day meeting on June 17 beginning at 9:00 a.m., at which time we will meet with the AMA delegates for discussion on



matters to come before the AMA annual session.

**DR. SANTARE:** I would like to read a letter which was presented to the Executive Committee and written by Dr. D. J. Kaderabek of Bedford concerning the necessity of certification and recertification. The reason I would like this letter read to the Board is to point out that Blue Cross is presently performing some PSRO activity. Here is a case where Blue Cross is reviewing payment because they contend the physician is not properly certifying and recertifying his hospital patients.

Dr. Santare read the letter and an extended discussion ensued. Following the discussion and upon motion by Dr. Goodman seconded by Dr. Schauwecker, it was voted to accept the suggestion of Dr. Gosman that unified criteria should be established pertaining to recertification and a further proposal to have Dr. Sprague Gardiner and representatives from the Indiana Hospital Association, Blue Cross and Blue Shield to appear before the Board to discuss this subject.

The next item discussed was TB testing. It was pointed out from the minutes of the Commission on Public Health that the position of the Indiana State Board of Health had been endorsed in that "a stabilized intermediate strength PPD(t) with Tween 80 be used as a testing material for tuberculosis. No action taken.

The meeting was adjourned.

**BOARD OF TRUSTEES**

Sunday, June 17, 1973

A joint meeting of the Board of Trustees and the AMA Delegates was called to order by Dr. Wilhelmus, chairman, at 9:00 a.m.

The roll call showed the following:

District	Trustee	
1	Gilbert M. Wilhelmus	Present
2	Paul W. Holtzman	Present
3	Eli Goodman	Present
4	Howard C. Jackson	Present
5	Cleon M. Schauwecker	Present
6	Paul M. Inlow	Present
7	John O. Butler	Absent
7	Joseph F. Ferrara	Present
8	Richard G. Ingram	Absent
9	William M. Sholty	Present
10	Vincent J. Santare	Absent
11	James A. Harshman	Present
12	William R. Clark	Present
13	G. Beach Gattman	Present

District	Alternate	
1	Raymond L. Newnum	Absent
2	Betty J. Dukes	Absent
3	Thomas A. Neathamer	Absent
4	William F. Blaisdell	Absent
5	William G. Bannon	Absent
6	Glen Ward Lee	Absent
7	Donald C. McCallum	Absent
7	John G. Pantzer	Absent
8	Jack L. Alexander	Absent
9	Max N. Hoffman	Absent
10	Martin J. O'Neill	Present
11	Lloyd L. Hill	Absent
12	Walter D. Greist	Absent
13	Donald S. Chamberlain	Absent

Officers:		
James H. Gosman	Present	
Joe Dukes	Absent	
Hugh K. Thatcher, Jr.	Absent	
Arvine G. Popplewell	Absent	
Frank B. Ramsey	Absent	

Executive Committee:		
Donald M. Kerr	Absent	
Vincent J. Santare	Absent	

AMA Delegates and Alternates:		
James A. Harshman	Present	
Eugene Senseny	Present	
Malcolm O. Scamahorn	Present	
Lowell H. Steen	Present	
Jack E. Shields	Absent	
Sprague H. Gardiner	Absent	
Myron H. Nourse	Absent	
A. Alan Fischer	Absent	
Ross L. Egger	Absent	
Kenneth O. Neumann	Present	
Thomas C. Tyrrell	Present	
Patrick J. V. Corcoran	Present	
Lall G. Montgomery	Present	
Peter R. Petrich,	Present	
(Immediate Past President)		

Staff:		
Robert J. Amick	Present	
Howard Grindstaff	Present	
John L. Walters	Present	
Michael H. McDermott	Present	
Kenneth W. Bush	Present	
James A. Waggener	Present	

The AMA delegation reported on matters referred to the following reference committees:

Malcolm O. Scamahorn —	Reference Committee on Constitution and Bylaws
Lowell H. Steen —	Reference Committee A
Thomas C. Tyrrell —	Reference Committee B
Patrick J. V. Corcoran —	Reference Committee C

James A. Harshman —  
Reference Committee D  
Kenneth O. Neumann —  
Reference Committee E  
Eugene F. Senseny and Jack E. Shields—  
Reference Committee F

Due to the absence of Drs. A. Alan Fischer and Ross L. Egger, matters referred to Reference Committees G and H were covered by other members of the delegation.

Chairman Wilhelmus called on Dr. Albert M. Donato, chairman of the ISMA Commission on Aging.

Dr. Donato reviewed the statement prepared by the Commission on Aging—copies of which had been given to the trustees. This statement has to do with problems relating to the Medicare and Medicaid programs and the reimbursement for professional care. Dr. Donato sought approval of the statement from the Board in order that the commission might have another meeting in September with other interested persons, at which time the statement would be presented as a policy of the Association. Following discussion, upon motion made and seconded, the Board voted to approve the statement.

**CHAIRMAN WILHELMUS:** I thank the delegation for your studious review of the material which will come before the AMA meeting in New York. We will now move on to other business. I recognize Dr. Sholty.

**DR. SHOLTY:** I have a request for a dues exemption for a member from my district who can no longer practice medicine. I move the acceptance.

The motion was properly seconded, put to a vote and carried.

**DR. SENSENY:** There will be a meeting of the AMA delegation at the rear of the room in about five minutes. I still want to discuss the business of the delegation at the AMA.

**DR. GOODMAN:** I think at the meeting in New York next week there is a very sensitive item which will demand deep study and consideration—that of PSRO. I would like to offer a suggestion that we instruct the AMA delegation to request that all votes on the PSRO issue be recorded by a roll-call vote.

**CHAIRMAN WILHELMUS:** Are you making this a motion?

**DR. GOODMAN:** Yes sir, I am.  
The motion was seconded by Dr. Sholty. The motion was discussed by several and, following the discussion, Dr. Goodman withdrew his motion. It was agreed that the delegation would be

happy to report how they voted on this particular issue.

CHAIRMAN WILHELMUS. In front of you is another item—a report from the Commission on Public Health dealing with TB testing.

Upon motion duly made and seconded, the report from the Commission on Public Health was accepted.

CHAIRMAN WILHELMUS: I would like to remind the AMA delegation we will have a caucus in the hospitality room on Sunday afternoon, following the meeting of the House of Delegates, and will open the room for hospitality on

Monday, Tuesday and Wednesday evenings.

CHAIRMAN WILHELMUS: I would also like to announce that the date for the next meeting of the Board has not been definitely set as yet but will probably be the last of July or the first of August.

DR. GOSMAN: I would like to again remind the Board that I would like to receive suggestions for names of persons from your districts to serve on the various reference committees of the House.

The Board then went into executive

session.

DR. GOSMAN: I would like to suggest that the Board urge the Commission on Public Information to seriously consider awarding some type of certificate to Channel 6 for their series of programs on the cost of medical care.

DR. GOODMAN: I would like to commend the chairman for the efficiency and the speed with which he has conducted the business of this Board meeting. This was one of the best sessions we have ever had.

There being no further business, the meeting was adjourned.

A limited quantity of June Yearbooks and 1973 Rosters are available at the JOURNAL OFFICE, 3935 N. Meridian, Indianapolis 46208. Place your order now.

Yearbook: \$5.00 each.

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## About Our Cover

### Notre Dame University

Familiar to many of our readers is this view across St. Mary's Lake, one of two on the campus (the other is St. Joseph's). The Administration Building, an internationally famous landmark, stands at the head of the main quadrangle and is surmounted by the familiar golden dome and a statue of Our Lady. The corridors of the first floor are decorated with Luigi Gregori's murals representing the Life of Christopher Columbus. It is the hub of campus life.

The University Church, whose steeple can be seen to the right of the Administration Building, was erected in 1871 and is dedicated to the Sacred Heart. It is the center of religious life at Notre Dame. It is a Gothic structure, 275 feet long and 120 feet wide, with a large crypt, numerous chapels, a set of chimes and a six-ton bell. Its carillon dates from 1856, and is believed to be the oldest in North America. In a side chapel is the magnificent Pieta by the late Professor Ivan Mestrovic of Notre Dame.

As presently constituted, Notre Dame consists of a Graduate School offering degree programs in 27 departments (22 Ph.D.) plus the Master of Business Administration Program. The Law School offers the juris doctor degree. There are four undergraduate colleges—Arts and Letters, Business Administration, Engineering and Science, offering bachelor degrees in 34 areas.

In addition, the University, now celebrating its 130th anniversary, has six institutes: Radiation Laboratory, Lobund Laboratory, Institute of International Studies, Center of Man in Contemporary Society, Institute for Educational Programs and the Urban Studies Institute.



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ered for display type advertising.

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Indianapolis, Indiana

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# The JOURNAL

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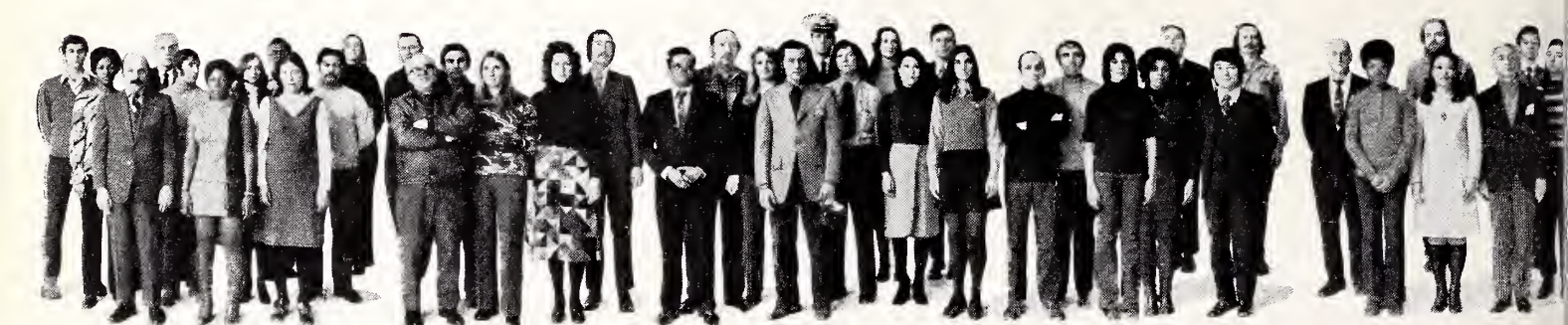


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**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

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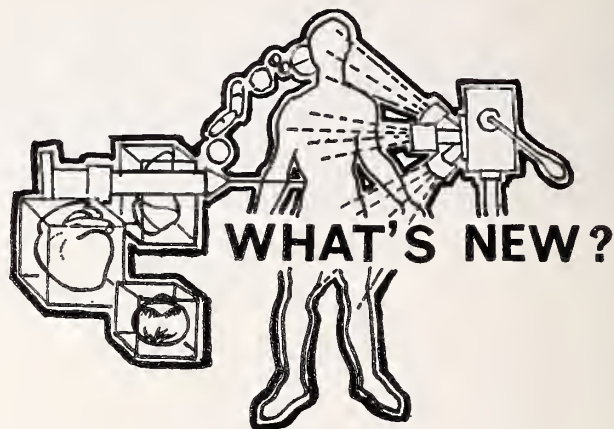


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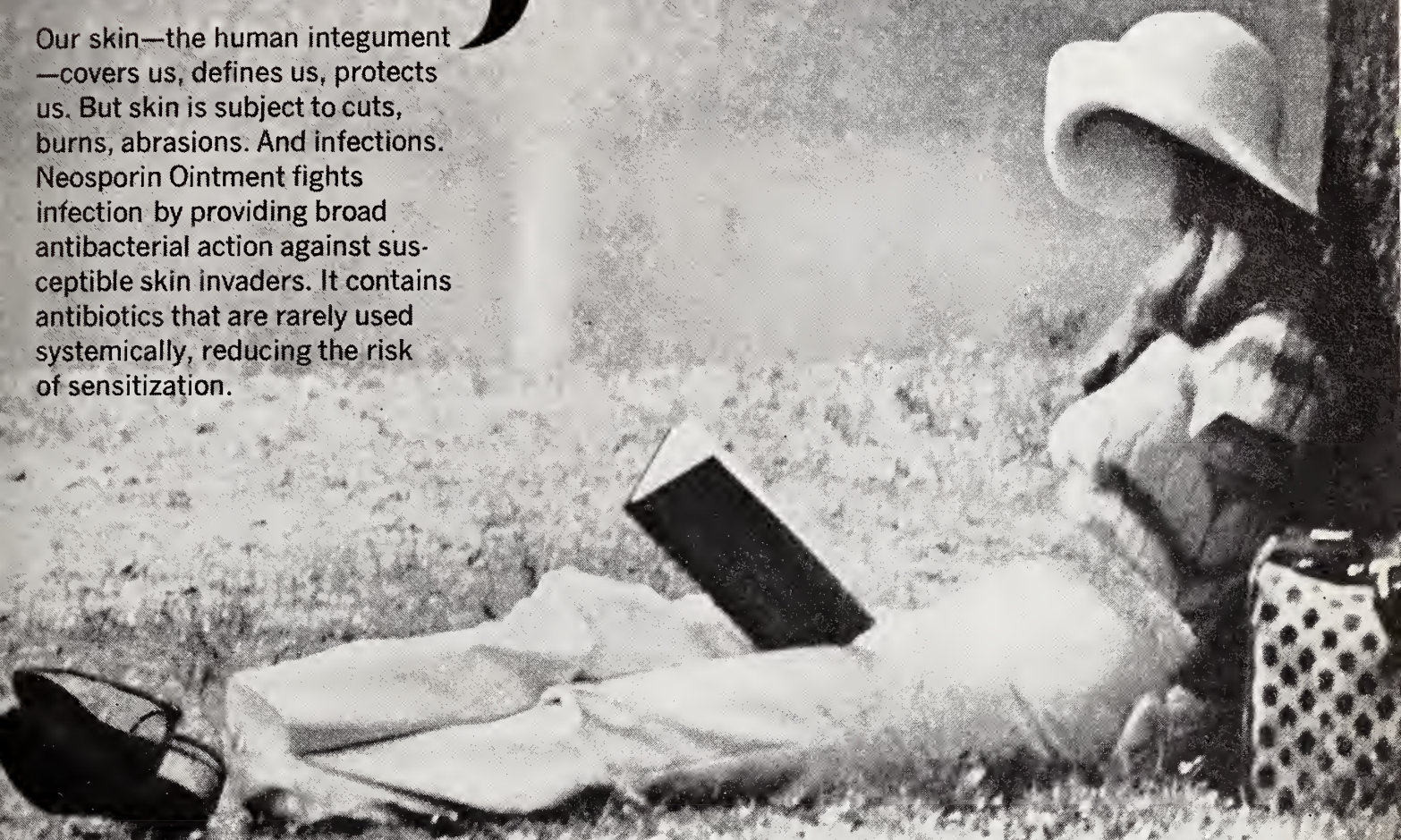
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News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.



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of the INDIANA STATE MEDICAL ASSOCIATION

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3935 N. Meridian, Indianapolis, Indiana 46208

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### EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glassy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

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Indexed in Hospital Literature Index.





# Bobo's back at the big top

After a rheumatoid arthritic flare-up.

**Important Note:** This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

**Indications:** Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

**Contraindications:** Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

**Warnings:** Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy

## Butazolidin® alka Geigy

Each capsule contains:  
100 mg. phenylbutazone USP  
100 mg. dried aluminum hydroxide gel USP  
150 mg. magnesium trisilicate USP

### If it doesn't work in a week, forget it.

and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug. **Precautions:** The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

**Adverse Reactions:** This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute

and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with over dosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement (B)98-146-070-R(10, 71)

For complete details, including dosage, please read full prescribing information

GEIGY Pharmaceuticals  
Division of CIBA-GEIGY Corporation  
Ardley, New York 10502





# More than sleep.

your choice of sleep medication  
is wisely based on more than  
sleep-inducing potential

## sleep with relative safety

Chronic tolerance studies have confirmed the relative safety of Dalmane (flurazepam HCl); no depression of cardiac or respiratory function was noted in patients administered recommended or higher doses for as long as 90 consecutive nights.

In most instances when adverse reactions were reported, they were mild, infrequent and seldom required discontinuance of therapy. Morning "hang-over" with Dalmane has been relatively infrequent. Dizziness, drowsiness, lightheadedness and the like have been the side effects noted most frequently, particularly in the elderly and debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

## sleep for 7 to 8 hours without need to repeat dosage

No sleep medication has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia patients given one 30-mg capsule of Dalmane at bedtime, on average: fell asleep within 17 minutes, had fewer nighttime awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to repeat dosage during the night.



sleep with  
consistency

Dalmane (flurazepam HCl) is a distinctive sleep medication—a benzodiazepine specifically indicated for insomnia. It is not a barbiturate or methaqualone, nor is it related chemically to any other available hypnotic.

When your evaluation of insomnia indicates the need for a sleep medication, consider Dalmane—a single entity nonnarcotic, non-barbiturate agent proved effective and relatively safe for relief of insomnia.

Dalmane has been shown to be consistently effective even during consecutive nights of administration, with no need to increase dosage.

**DALMANE**<sup>®</sup>  
(flurazepam HCl)

**When restful sleep  
is indicated**

**One 30-mg capsule h.s. —usual adult dosage**  
(15 mg may suffice in some patients).

**One 15-mg capsule h.s. —initial dosage for elderly or  
debilitated patients.**

**Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:**

**Indications:** Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

**Contraindications:** Known hypersensitivity to flurazepam HCl.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

**Precautions:** In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

**Adverse Reactions:** Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

**Supplied:** Capsules containing 15 mg or 30 mg flurazepam HCl.



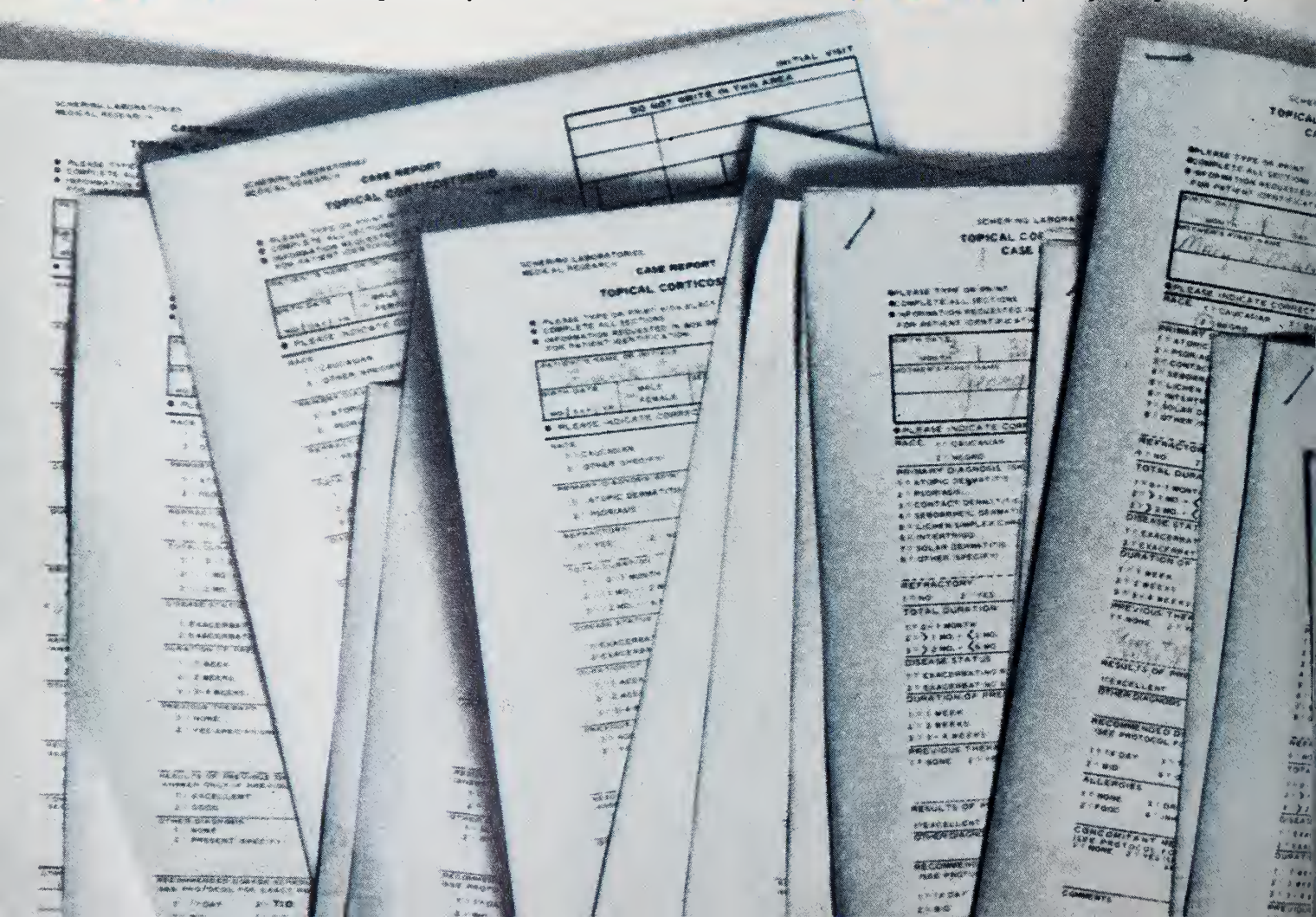
ROCHE LABORATORIES  
Div., Hoffmann-La Roche Inc.  
Nutley, New Jersey 07110



*in study...after study...after study*<sup>I-6</sup>

**85% in psoriasis**  
(150 of 177 patients)<sup>1</sup>

**92%** in atopic eczema  
(231 of 251 patients)<sup>1</sup>





Schering

# Valisone<sup>®</sup>

brand of

## betamethasone valerate (0.1%) Cream/Ointment

Plus economy *B.i.d.* dosage often found effective!  
Available in 5, 15, and 45 Gm. tubes.

96% in contact dermatitis  
(81 of 84 patients)<sup>1</sup>

### CLINICAL CONSIDERATIONS:

**Description** VALISONE products contain betamethasone valerate (9-fluoro-11 $\beta$ , 17, 21-trihydroxy-16 $\beta$ -methylpregna-1,4-diene-3,20-dione 17-valerate). Each gram of VALISONE Cream 0.1% contains 1.2 mg. betamethasone valerate (equivalent to 1.0 mg. betamethasone) in a soft, white, hydrophilic cream of water, mineral oil, petrolatum, polyethylene glycol 1000 monocetyl ether, cetostearyl alcohol, monobasic sodium phosphate, and phosphoric acid; 4-chloro-m-cresol is present as a preservative. Each gram of VALISONE Ointment 0.1% contains 1.2 mg. betamethasone valerate (equivalent to 1.0 mg. betamethasone) in an ointment base of liquid and white petrolatum, and hydrogenated lanolin. VALISONE Cream and Ointment contain no parabens.

**Indications** VALISONE Cream and Ointment are indicated for the relief of the inflammatory manifestations of corticosteroid-responsive dermatoses.

**Contraindications** VALISONE Cream and Ointment are contraindicated in vaccinia and varicella. Topical steroids are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

**Precautions** If irritation develops with the use of VALISONE Cream or Ointment, treatment should be discontinued and appropriate therapy instituted. In the presence of an infection, the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled. If extensive areas are treated or if the occlusive technique is used, the possibility exists of increased systemic absorption of the corticosteroid and suitable precautions should be taken. Although topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use in pregnant females has not been absolutely established. Therefore, they should not be used extensively in pregnant patients, in large amounts, or for prolonged periods of time. VALISONE Cream and Ointment are not for ophthalmic use.

**Adverse Reactions** The following local adverse reactions have been reported with topical corticosteroids: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneform eruptions, and hypopigmentation. The following may occur more frequently with occlusive dressings than without such therapy: maceration of the skin, secondary infection, skin atrophy, striae, and miliaria.

**Dosage and Administration** Apply a thin film of VALISONE Cream or Ointment to the affected skin areas one to three times a day. Clinical studies of VALISONE have indicated that dosage only once or twice a day is often feasible and effective. AUGUST 1972

For more complete details, consult Schering literature available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.

**References:** (1) Files of Headquarters Medical Research Division, Schering Corporation. (2) Carter, V. H., and Noojin, R. O.: *Curr. Therap. Res.* 9:253, 1967. (3) Falk, M. S.: *Cutis* 2:788, 1966. (4) Goldblum, R. W.: *Pennsylvania Med.* 69:50, 1966. (5) Nierman, M. M.: *J. Indiana M. A.* 10:1184, 1966. (6) Zimmerman, E. H.: *Arch. Dermat.* 95:514, 1967.

DO NOT WRITE IN THIS AREA

SCHERING LABORATORIES  
TOPICAL CORTICOSTEROID  
CASE REPORT

PLEASE TYPE OR PRINT  
COMPLETE ALL SECTIONS  
AND INFORMATION REQUESTED IN BOX BELOW MUST BE SUPPLIED  
FOR PATIENT IDENTIFICATION

DO NOT WRITE IN THIS AREA

INITIAL VISIT

PLEASE INDICATE CORRECT RESPONSE BY CIRCULING APPROPRIATE NUMBER

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# ROCHE announces new

# BACTRIM<sup>TM</sup>

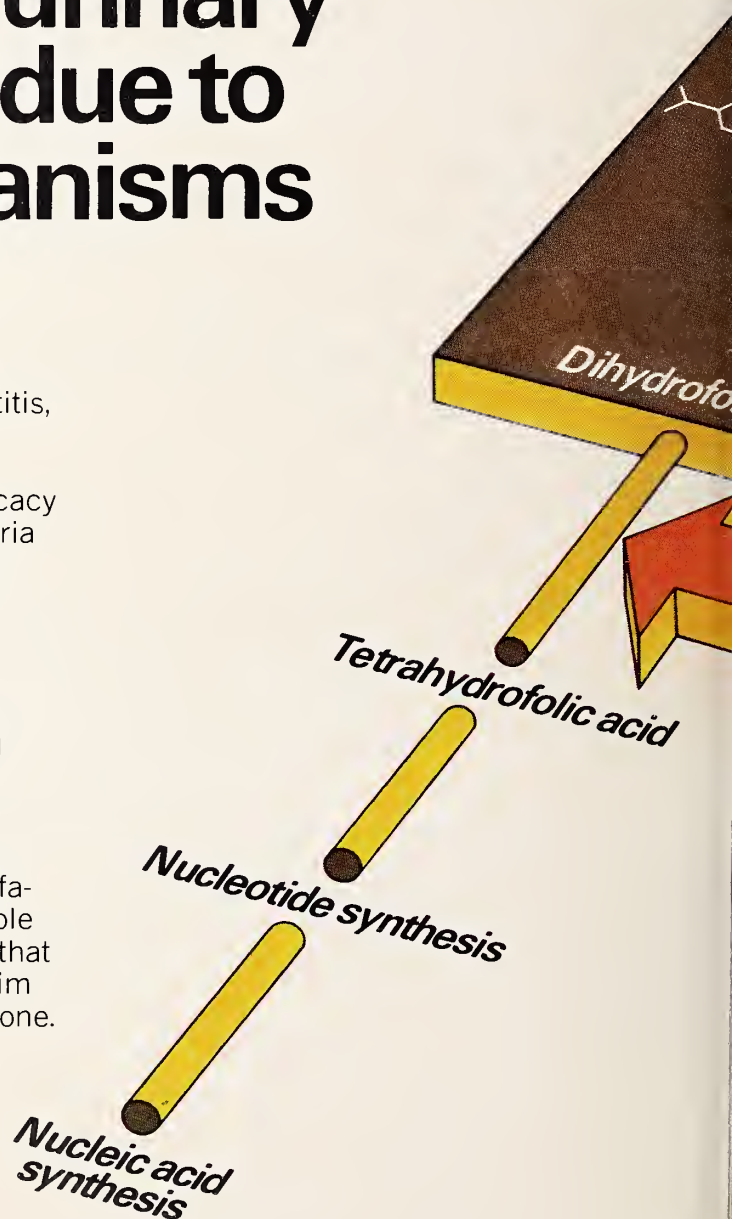
Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

## a new type of antibacterial for a two-pronged attack against chronic urinary tract infections due to susceptible organisms

Bactrim is highly effective in the treatment of these infections—primarily pyelonephritis, pyelitis and cystitis, when due to susceptible organisms (usually *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, and, less frequently, indole-positive proteus species). This efficacy is related to the unique mode of action against bacteria (see opposite page), an action that, in effect, makes Bactrim a new type of antibacterial.

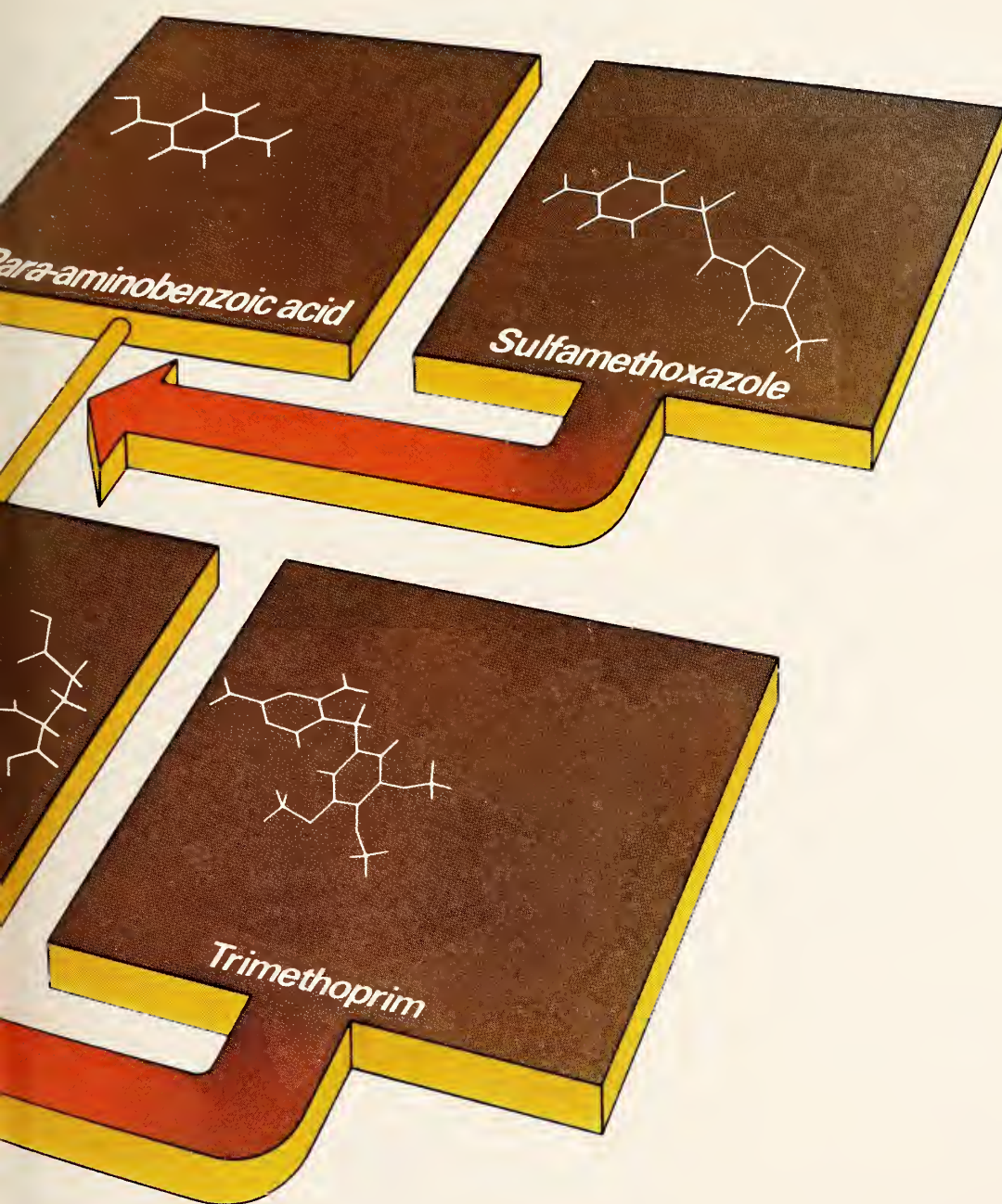
### Bactrim significantly superior to constituents in patients with obstructive complications

In the presence of obstructive uropathy, Bactrim has demonstrated efficacy which is superior to either sulfamethoxazole or trimethoprim alone against susceptible organisms. In addition, *in vitro*\* studies have shown that bacterial resistance develops more slowly with Bactrim than with either trimethoprim or sulfamethoxazole alone.



\*Please note that clinical conclusions cannot be extrapolated from *in vitro* studies.





## Interrupts life cycle of susceptible bacteria

Unique mode of action interrupts the life cycle at two important points, thereby impeding the production of nucleic acids and proteins essential to these bacteria. These consecutive interruptions occur because sulfamethoxazole and trimethoprim resemble naturally existing substrates. By competitive replacement of these substrates, they inhibit further synthesis.

new **BACTRIM** <sup>T.M.</sup>

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

**for chronic urinary tract infections**

Before prescribing, please see complete product information on last page of advertisement.

## Excellent clinical response in chronic urinary tract infections

A multiclinic, double-blind study\* of response to a ten-day course of therapy in 471† patients with chronic urinary tract infections demonstrated the superiority of Bactrim. On the 10th day after initiation of therapy, 91.7% (of 168 patients) showed significant bacteriological response to Bactrim compared with 81.2% (of 144 patients) to trimethoprim and 64.5% (of 155 patients) to sulfamethoxazole. In patients with obstructive complications, 10th day response was 94.8% (of 97 patients) to Bactrim, 72.9% (of 85 patients) to trimethoprim and 58.5% (of 94 patients) to sulfamethoxazole.

## Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after ten-day therapy with Bactrim, 68.4% of patients with chronic urinary tract infections maintained response for up to 42 consecutive days, compared with 59.7% with trimethoprim and 44.4% with sulfamethoxazole. In patients with obstruction, 70.8% of those on Bactrim maintained response for up to 42 consecutive days, compared

with 49.4% on trimethoprim and 38.8% on sulfamethoxazole. The figures are particularly remarkable in cases with urinary obstruction—cases regarded as being notoriously difficult to treat.

## To date, low incidence of significant side effects

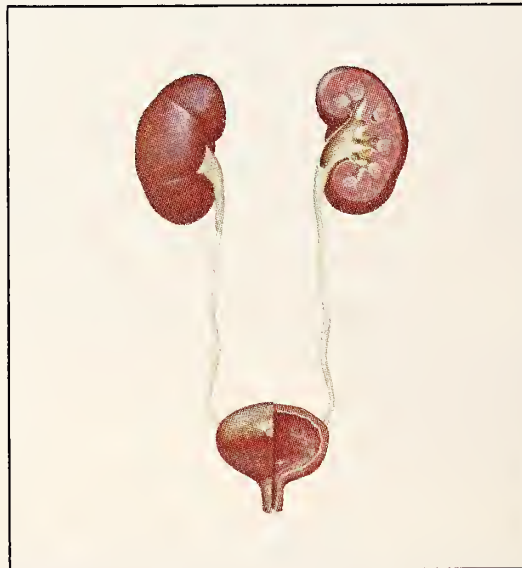
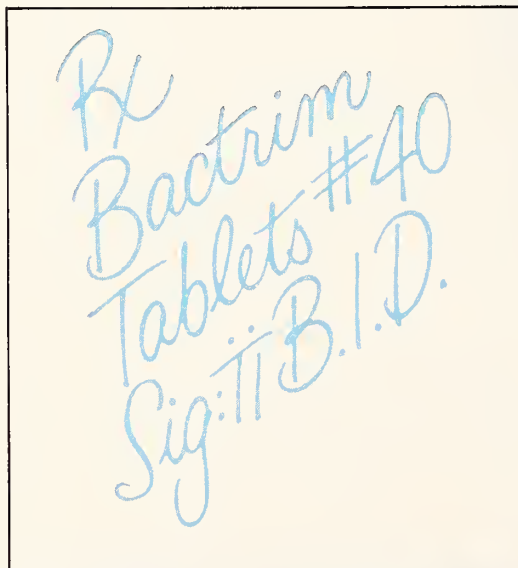
Although Bactrim demonstrated impressive clinical results, it is important to note that the incidence of clinically significant adverse effects was low, mainly nausea and/or vomiting, rash, leukopenia, SGOT increase and creatinine increase.

Bactrim should be given with caution to patients with impaired renal or hepatic function, possible folate deficiency and to those with severe allergy or bronchial asthma. Adequate fluid intake must be maintained. Complete blood counts, urinalyses with careful microscopic examination, and renal function tests should be performed during therapy.

Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.

**Usual adult dosage: two tablets every twelve hours for 10 to 14 days; no loading dose required.**

\* Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110  
† 4 patients not available for evaluation at day 10.



**new BACTRIM<sup>TM</sup>**

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

**for chronic urinary tract infections**



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110

**Before prescribing, please consult complete product information on facing page.**



## Complete Product Information:

**Description:** Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is *N*-(5-methyl-3-isoxazolyl)sulfanilamide. It is an almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

**Actions: Microbiology:** Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with *para*-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

*In vitro* studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

*In vitro* serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa*. The following organisms are usually susceptible: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis* and indole-positive proteus species.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms (MIC—mcg/ml)				
Bacteria	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20) TMP                      SMX	
<i>Escherichia coli</i>	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
<i>Proteus</i> spp. indole positive	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
<i>Proteus mirabilis</i>	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
<i>Klebsiella-Enterobacter</i>	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

**Human Pharmacology:** Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. On repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma decreases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than are the concentrations in the blood. When administered together as in Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

**Indications:** Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, and, less frequently, indole-positive proteus species).

**Important note:** Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.

**Contraindications:** Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction Studies).

**Warnings:** Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

**Precautions:** Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

**Adverse Reactions:** For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

**Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

**Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

**Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

**C.N.S. reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

**Miscellaneous reactions:** Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

**Dosage and Administration: Not recommended for use in children under 12 years of age.**

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

**How Supplied:** Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

**Reproduction Studies:** In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

# BACTRIM<sup>TM</sup>

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110



# THE INDIANA STATE MEDICAL ASSOCIATION

3935 N. Meridian, Indianapolis 46208—Telephone 925-7545  
ANNUAL CONVENTION—OCTOBER 6-11, 1973—Indianapolis

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President-Elect—Joe Dukes, Dugger 47848  
Treasurer—Hugh K. Thatcher, Jr., 4548 College Ave., Indianapolis 46205.

Assistant Treasurer—Arvine G. Popplewell, 960 Locke St., Indianapolis 46202  
Chairman of Executive Committee—Donald M. Kerr, 2900 W. 16th St., Bedford 47421  
Executive Secretary—Mr. James A. Waggener, 3935 N. Meridian, Indianapolis 46208.

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District	Term Expires
1—Gilbert M. Wilhelmus, Evansville (Chairman)	Oct. 1974
2—Paul W. Holtzman, Bloomington	Oct. 1975
3—Eli Goodman, Charlestown	Oct. 1973
4—Howard C. Jackson, Madison	Oct. 1974
5—Cleon M. Schauwecker, Greencastle	Oct. 1975
6—Paul M. Inlow, Shelbyville	Oct. 1973
7—John O. Butler, Indianapolis	Oct. 1974
7—Joseph F. Ferrara, Franklin	Oct. 1975
8—Richard Ingram, Montpelier	Oct. 1975
9—William M. Sholty, Lafayette	Oct. 1973
10—Vincent J. Santare, Munster	Oct. 1974
11—James A. Harshman, Kokomo	Oct. 1975
12—William R. Clark, Fort Wayne	Oct. 1973
13—G. Beach Gattman, Elkhart	Oct. 1974

## SECTION OFFICERS 1972-73

### Section on Surgery:

Chairman—Malcolm L. Wrege, Indianapolis  
Vice-chairman—J. Robert Edwards, Auburn  
Secretary—Lowell Hillis, Logansport

### Section on Internal Medicine:

Chairman—Robert L. Rudesill, Indianapolis  
Vice-chairman—John L. Ferry, Hammond  
Secretary—Chas. W. Magnuson, South Bend

### Section on Family Physicians

Chairman—James T. Anderson, Greenfield  
Vice-chairman—James R. Daggy, Richmond  
Secretary—David M. Hadley, Plainfield

### Section on Obstetrics and Gynecology:

Chairman—Jerome F. Doss, Kokomo  
Vice-chairman—David E. Copher, Indianapolis  
Secretary—Charles R. Thomas, Indianapolis

### Section on Ophthalmology and Otolaryngology:

Chairman—Kenneth Isenogle, Fort Wayne  
Vice-chairman—Wallace Dyer, Evansville  
Secretary—David Kenney, Indianapolis

### Section on Anesthesiology:

Chairman—Willis W. Stogsdill, Indianapolis  
Secretary—David P. Lehman, Kokomo

### Section on Public Health and Preventive Medicine:

Chairman—Fred Poehler, La Fontaine  
Vice-chairman—Robert M. Seibel, Nashville  
Secretary—David Edwards, Indianapolis

## ALTERNATES

District	Term Expires
1—Raymond Newnum, Evansville	1973
2—Betty Dukes, Dugger	1974
3—Thomas Neathamer, Jeffersonville	1974
4—William Blaisdell, Seymour	1973
5—William G. Bannon, Terre Haute	1973
6—Glen Ward Lee, Richmond	1975
7—John Pantzer, Indianapolis	1975
7—Donald McCallum, Indianapolis	1974
8—Jack L. Alexander, Muncie	1973
9—Max N. Hoffman, Covington	1974
10—Martin O'Neill, Valparaiso	1975
11—Lloyd L. Hill, Peru	1974
12—Walter D. Griest, Fort Wayne	1974
13—Donald S. Chamberlain, South Bend	1973

### Section on Radiology:

Chairman—Dale B. Parshall, Elkhart  
Vice-chairman—James G. Lorman, Fort Wayne  
Secretary—L. Ray Stewart, Evansville

### Section on Nervous and Mental Diseases:

Chairman—Wesley A. Kissel, Indianapolis  
Vice-Chairman—Wallace R. Van den Bosch, Lafayette  
Secretary—Richard N. French, Jr., Indianapolis

### Section on Pathology and Forensic Medicine:

Chairman—Clyde Culbertson, Indianapolis  
President-elect—Wei-Ping Loh, Gary  
Secretary—Victor Muller, Indianapolis

### Section on Pediatrics:

Chairman—George F. Parker, Indianapolis  
Vice Chairman—John R. Poncher, Valparaiso  
Secretary—Robert M. Sweeney, South Bend

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President—Lindley H. Wagner, Lafayette  
Vice President—John L. Cullison, Muncie  
Secretary—W. Thomas Spain, Evansville

### Section on Cutaneous Medicine:

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Vice-chairman—Howard R. Gray, Indianapolis  
Secretary—Victor G. Hackney, Indianapolis

### Section on College Health Physicians:

Chairman—Jahn Miller, Bloomington  
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Terms expire December 31, 1973:

Delegates	Alternates
Jack E. Shields Brownstown	Patrick J. V. Corcoran Evansville
Lowell H. Steen Hammond	Thomas C. Tyrrell Hammond

Terms expire December 31, 1974:

Delegates	Alternates
James A. Harshman Kokomo	A. Alan Fischer Indianapolis
Eugene F. Senseney Fort Wayne	Ross L. Egger Daleville
Malcolm O. Scamahorn Pittsboro	Kenneth O. Neumann Lafayette

## 1972-73 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1.	William Dye, Oakland City	Martin J. Bender, Evansville	
2.		J. S. Brown, Carlisle	
3.	Claude J. Meyer, Jeffersonville	Robert K. McKechnie, Jeffersonville	September 26, 1973, Clarksville
4.	Joe M. Black, Seymour	John W. Ripley, Seymour	Seymour
5.	J. Franklin Swain, Rockville	Antolin M. Montecillo, Clinton	
6.	James H. Tower, Jr., Shelbyville	Arlington M. Hudson, Connersville	Connersville
7.	Eric Clark, Plainfield	M. O. Scamahorn, Pittsboro	
8.	David Dietz, Muncie	Arthur Jay, Muncie	Aug. 29, 1973, Muncie
9.	Milton W. Erdel, Frankfort	Harry T. Stout, Frankfort	June 13, 1974, Frankfort
10.	Lambro Dimitroff, Hammond	Mario D. Mansueto, Munster	Sept. 5, 1973, Valparaiso
11.	Joseph S. Bean, Logansport	Fred Poehler, La Fontaine	Sept. 19, 1973, Marion
12.	George C. Manning, Fort Wayne	William B. Hughes, Waterloo	Sept. 13, 1973, Fort Wayne
13.	James Rimel, Plymouth	David L. Spalding, Mishawaka	Sept. 12, 1973, Plymouth



# We believe in being better



We believe in being better.

A strong statement, but one we, Blue Cross and Blue Shield of Indiana, can back up. We're more than an insurance company. We believe our job includes working to stabilize health care costs every way possible—through hospital rate reviews, peer reviews of physician charges, out-patient surgery, pre-admission testing. Do you realize that the hospital cost in Indiana is \$20 per day below the national average?

We innovate. For instance, we cover mentally and emotionally handicapped people and alcoholism treatment in specialized institutions. And right now we have 7 experimental health care delivery systems in operation at 11 facilities across Indiana.

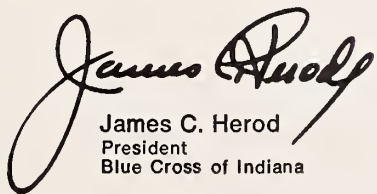
We pay health care bills promptly. We operate our business on about 6 cents out of each dollar received from our members.

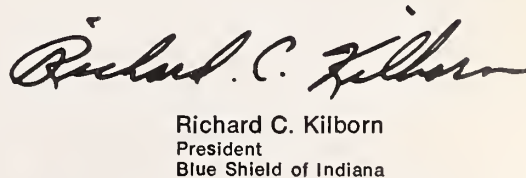
Our membership card is the best known and most trusted one at important places like hospital and physician reception desks throughout America.

We relieve employers of health care "homework" by doing the paperwork directly with hospitals and physicians.

Good Service? We have nearly 2 million members, but can answer questions from your membership records quickly after hearing your Identification Number.

But Blue Cross and Blue Shield of Indiana will not stop here. We have a philosophy that keeps us unsatisfied and uncomfortable enough to continue searching for ways to improve. It's a way of life. For we believe in being better.

  
James C. Herod  
President  
Blue Cross of Indiana

  
Richard C. Kilborn  
President  
Blue Shield of Indiana



**Blue Cross  
Blue Shield**  
of Indiana

120 West Market St.  
Indianapolis, Ind. 46204

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(One of a series of ads being run in key Hoosier newspapers)



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Bartholomew-Brown	Charles A. Rau, Columbus	Mr. Larry L. Pickering, Exec. Secy., 212 Med. Ctr. Bldg., Fort Wayne
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# Recommendations<sup>†</sup> on Combination Live Virus Vaccines

## American Academy of Pediatrics

### Committee on Infectious Diseases

In the September 15, 1971 AAP Newsletter sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

<sup>†</sup>For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.

## United States Public Health Service

### Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidity and Mortality Weekly Report*, the Advisory Committee on Immunization Practices of the United States Public Health Service presented recommendations on the use of combination live virus vaccines. The committee stated that:

- "Data indicate that antibody response to each component of these combination vaccines is comparable with antibody response to the individual vaccines given separately."
- "There is no evidence that adverse reactions to the combined products occur more frequently or are more severe than known reactions to the individual vaccines (see pertinent ACIP recommendations)."
- "The obvious convenience of giving already selected antigens in combined form should encourage consideration of using these products when appropriate."





# M-M-R\*

(MEASLES, MUMPS AND RUBELLA  
VIRUS VACCINE, LIVE | MSD)

Single-dose vials

M-M-R, given in a single injection, fits easily into your routine immunization program for well babies. Given at age 12 months, M-M-R provides for vaccination early in life against measles, mumps, and rubella.

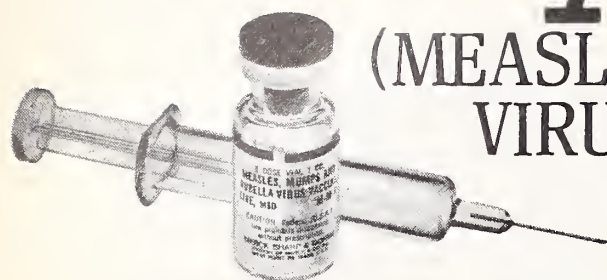
MSD suggested immunization schedule for well babies	
Age	Vaccine(s)
2 months	DPT (diphtheria-pertussis-tetanus) Oral poliomyelitis vaccine (triple)
3 months	DPT <sup>1</sup>
4 months	DPT Oral poliomyelitis vaccine (triple)
6 months	Oral poliomyelitis vaccine (triple)
12 MONTHS	M-M-R (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE, MSD)

1. This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.  
Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

\*Trademark of Merck & Co., Inc.

For a brief summary of prescribing information, please see following page.





# M-M-R

## (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials

No untoward reactions peculiar to the combination vaccine (M-M-R) have been reported.

Moderate fever (101-102.9 F) occurs occasionally. High fever (over 103 F) occurs less commonly. On rare occasions, children who develop fever may exhibit febrile convulsions. Rash (usually minimal and without generalized distribution) may occur infrequently.

Since clinical experience with measles, mumps, and rubella virus vaccines given individually indicates that very rarely encephalitis and other nervous system reactions have occurred, such reactions may also occur with M-M-R. A cause and effect relationship, however,

has not been established.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Must not be given to women who are pregnant or who might become pregnant within three months following vaccination.

**Contraindications:** Pregnancy or possibility of pregnancy within three months following vaccination; infants less than one year old; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; therapy with ACTH, corticosteroids, irradiation, alkylating agents, or antimetabolites; blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems; gamma globulin deficiency, i.e., agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia. **Precautions:** Administer subcutaneously; do not give intravenously. Epinephrine should be available for immediate use should an anaphylactoid reaction occur. Should not be given less than one month before or after immunization with other live virus vaccines; vaccination should be deferred for at least six weeks following blood transfusions or administration of more than 0.02 cc immune serum globulin (human) per pound of body weight, or human plasma.

Due caution should be employed in children with a history of febrile convulsions, cerebral injury, or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur after vaccination.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Attenuated live virus measles and mumps vaccines, given separately, may temporarily depress tuberculin skin sensitivity; therefore, if a tuberculin test is to be done, it should be scheduled before vaccination, to avoid the possibility of a false negative response.

Before reconstitution, refrigerate vaccine at 2-8 C (35.6-46.4 F) and protect from light. Use only diluent supplied to reconstitute vaccine. If not used immediately, return reconstituted vaccine to refrigerator at 2-8 C (35.6-46.4 F), and discard after eight hours.

**Adverse Reactions:** Fever, rash; mild local reactions such as erythema, induration, tenderness, regional lymphadenopathy; parotitis; thrombocytopenia and purpura; allergic reactions such as urticaria; arthritis, arthralgia, and polyneuritis.

Occasionally, moderate fever (101-102.9 F); less commonly, high fever (above 103 F); rarely, febrile convulsions.

Encephalitis and other nervous system reactions that have occurred very rarely with the individual vaccines may also occur with the combined vaccine.

Transient arthritis, arthralgia, and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. Such reactions have been reported with live attenuated rubella virus vaccines. Symptoms relating to joints (pain, swelling, stiffness, etc.) and to peripheral nerves (pain, numbness, tingling, etc.) occurring within approximately two months after immunization should be considered as possibly vaccine related. Symptoms have generally been mild and of no more than three days' duration. The incidence in prepubertal children would appear to be less than 1% for reactions that would interfere with normal activity or necessitate medical attention.

**How Supplied:** Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 TCID<sub>50</sub> (tissue culture infectious doses) of measles virus vaccine, live, attenuated, 5,000 TCID<sub>50</sub> of mumps virus vaccine, live, and 1,000 TCID<sub>50</sub> of rubella virus vaccine, live, expressed in terms of the assigned titer of the NIH Reference Measles, Mumps, and Rubella Viruses, and approximately 25 mcg neomycin, with a disposable syringe containing diluent and fitted with a 25-gauge, 5/8" needle. Also in boxes of 10 single-dose vials nested in a pop-out tray with a separate box of 10 diluent-containing syringes.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486

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# *Annual Meeting Dates of Professional Medical and Allied Organizations*

## **AMERICAN MEDICAL ASSOCIATION ANNUAL CONVENTION**

**Date** Dec. 1-5, 1973  
**Place** Anaheim, Calif.

## **NORTHERN INDIANA PSYCHIATRIC SOCIETY**

**Date** Fourth Wednesday of every  
month, September through June  
**Place** For location and program, inquire  
Jon Leipold, M.D.,  
919 E. Jefferson Blvd.  
South Bend 46622

## **INDIANA STATE MEDICAL ASSOCIATION CONVENTION**

**Date** October 6-11, 1973  
**Place** Indianapolis Convention-  
Exposition Center

## **INDIANA ACADEMY OF FAMILY PHYSICIANS**

**Date** April 2-4, 1974  
**Place** Stouffer's Indianapolis Inn

## **INDIANA PSYCHIATRIC SOCIETY**

**Date** Second Wednesday of September,  
November, January, February,  
March and April  
**Place** For time and place, inquire Wes-  
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## **INDIANA SOCIETY OF INTERNAL MEDICINE AND AMERICAN COLLEGE OF PHYSICIANS**

**Date** October 10, 1973  
**Place** Indianapolis Convention-Exposi-  
tion Center

## **INDIANA CHAPTER, AMERICAN ACADEMY OF PEDIATRICS**

**Date** Sept. 26-27, 1973  
**Place** Ramada Inn, Nashville

## **INDIANA ASSOCIATION OF PATHOLOGISTS**

**Date** December 1, 1973  
**Place** Indianapolis

## **INDIANA STATE NURSES ASS'N**

**Date** October 11-13, 1973  
**Place** French Lick

## **INTERNATIONAL COLLEGE OF SURGEONS**

**Date** December 1, 1973  
**Place** Indianapolis

## **INDIANA LUNG ASSOCIATION**

**Date** May 7-8, 1974  
**Place** Indianapolis

## **INDIANA THORACIC SOCIETY**

**Date** May 7-8, 1974  
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## Non-Specific Infantile Diarrhea

JOHN BLAIR, M.D.  
JOSEPH F. FITZGERALD, M.D.  
Indianapolis

**N**ON-SPECIFIC diarrhea in infancy continues to be a major problem for all physicians caring for children. A significant percentage of patients require hospitalization and, unfortunately, a small, but real, percentage expire. We feel that failure to allow for mucosal regeneration contributes to the morbidity and mortality of non-specific infantile diarrhea. We would like to present a treatment schedule to our readers which we have found successful. The basic philosophy of "putting the bowel at rest" is not new, although its import has received less weight with the increased use of antidiarrheal preparations.

Antibiotic therapy is frequently employed in infantile diarrhea in spite of the fact that a causative agent is rarely identified. Kuzemko<sup>1</sup> found a likely etiologic agent (viral or bacterial) in 40% of patients with diarrhea while Gramblet et al.<sup>2</sup> were unable to identify a causative agent in 65% of their patients with presumed infectious gastroenteritis.

Dr. Blair is a resident in Pediatrics at the Indiana University Medical Center, Indianapolis.

Dr. Fitzgerald is chief of the Gastroenterology Section, Department of Pediatrics, Indiana University Medical Center, Indianapolis 46202.

In many cases, the diarrhea continues much longer than one would anticipate. Several proposals have been offered to explain this perpetuation of diarrhea. They include: abnormal bowel motility; loss of mucosal integrity; invasion of damaged bowel mucosa by bacteria; "sprue-like" changes; diminished mitotic regeneration of the intestinal mucosa; impaired pancreatic and other digestive secretions; lactose intolerance;<sup>3</sup> as well as vitamin and mineral malabsorption, and starvation.<sup>4</sup>

Lactose intolerance has been extensively studied. A secondary lactase deficiency (hypolactasia) can occur when the mucosa, primarily the brush border, is damaged.<sup>5</sup> The unhydrolyzed disaccharide increases the osmolality of the luminal contents and provides substrate for fermentation by enteric bacteria. The former results in the production of diarrhea on an osmotic basis while the latter results in irritation and the subsequent perpetuation of diarrhea. Minor injury can result in hypolactasia since lactase activity is marginal in the normal state.<sup>6</sup> Recently it has been shown that 77% of patients with severe diarrhea of any etiology have lactose intolerance at some time during their ill-

ness.<sup>7</sup> An intolerance to all monosaccharides and disaccharides has developed in some cases where lactose intolerance has persisted for three weeks or longer.<sup>7</sup> Lactose intolerance has also been shown to complicate malnutrition.<sup>4</sup>

It is generally agreed that a vicious cycle can be started regardless of the initial cause of diarrhea. We therefore put the bowel at rest initially. If dehydration is present, the infant is administered parenteral fluids calculated to repair deficits in 24-28 hours. He is given nothing by mouth during this initial period. During this period the intestinal mucosa has an opportunity to regenerate. Persistence at oral feeding frequently delays regeneration and prolongs the illness. Even clear liquids can present a carbohydrate load to the regenerating mucosa which it is unable to handle. This results in a persistence of mucosal irritation and a continuation of the diarrheal process.

Once the deficits have been corrected and the stooling has decreased, the patient is offered small amounts of glucose water (Gatorade,<sup>8</sup> Pedialyte,<sup>9</sup> etc.). The volume is gradually increased until the infant's maintenance water require-

TABLE I

## TREATMENT OF SEVERE NON-SPECIFIC DIARRHEA

I	Correction of dehydration and acidosis with IV therapy	24-48 hrs.
	↓	↓
II	Trial of oral glucose H <sub>2</sub> O	24 hrs.
	↓	↓
III	1/4 strength formula	24 hrs.
	↓	↓
IV	1/2 strength formula	24 hrs.
	↓	↓
V	Full strength formula	At least 1 month.

If diarrhea recurs, the patient is immediately returned to Step II and advanced more slowly. If a standard formula was employed, a non-lactose formula is substituted.

ment is met. Gradual progression allows for reacclimation to the glucose and volume load. The infant is maintained on glucose water for at least 24 hours before instituting formula.

Formula is initially given as a 25% solution (1/4 strength) in a volume which fulfills fluid requirements (similar to the glucose water administered one day earlier). We anticipate prolonged lactose intolerance in patients who have experienced profound diarrhea resulting in significant dehydration and use a non-lactose-containing formula (Isomil,<sup>10</sup> Nutramigen,<sup>11</sup> etc.) in these circumstances. Lactase activity does not return to normal levels for 2-4 weeks following a significant insult to the small intestinal mucosa. In less severe cases we usually begin with one of the standard formulas (Similac,<sup>12</sup> Enfamil,<sup>13</sup> Bremil,<sup>14</sup> etc.) but quickly change to a non-lactose-containing formula if increased stooling (volume and frequency) ensues.

The concentration of the formula is increased at 24-hour intervals as outlined in Table I. The patient is followed closely during the advancement, and if we note an increase in stool number, volume or water content at any point, we immediately switch to glucose water. A recurrence of diarrhea is frequently preceded by a decrease in stool pH (be-

low 6). We have found that abrupt return to glucose water usually results in a rapid decrease in stool output, thereby preventing the development of dehydration. The patient is then advanced more slowly, usually at intervals of 36-48 hours. Our experience has taught patience.

The stool pH has been shown to correlate fairly well with the presence of carbohydrate in the stool.<sup>7</sup> The determination must be performed on a fresh stool specimen in order to prevent artificial lowering as a consequence of prolonged bacterial fermentation. A stool record which includes pH, hematest, volume, and a general description of each stool is kept at the infant's bedside. House officers perform stool clintest periodically in a further search for the presence of unabsorbed carbohydrate. One part liquid stool is mixed with two parts water; 15 drops of this mixture are then added to a clean Ames test tube and a fresh clintest tablet is dropped into the tube. The urine chart is employed in the evaluation of the reaction. A reading of 1/2% or greater suggests the presence of increased reducing substance in the stool. We consider 1/4 - 1/2% a gray zone demanding further determinations. A normal stool pH can be obtained with incomplete carbohydrate absorption (and therefore a positive stool clintest) if the enteric

bacterial flora has been altered by antibiotic therapy.<sup>7</sup>

Very rarely an infant will be unable to tolerate the non-lactose formula. In these cases we have employed Cho-free,<sup>15</sup> a soy-protein formula which does not contain carbohydrate; and Pregestimil,<sup>16</sup> which contains glucose, medium-chain-triglycerides, and protein in a predigested, readily assimilable form. When the former is employed, carbohydrate can be added as tolerated. One must remember that the prepared formula contains only 13 cal/oz. prior to the addition of carbohydrate. The latter has great applicability in the treatment of chronic diarrhea, particularly malabsorption syndromes. We continue the non-lactose or special formula for at least one month before any attempt at switching to a standard formula is made. The switch is gradual rather than abrupt. The development of diarrhea dictates return to the non-lactose or special formula. One must keep in mind that secondary lactose intolerance can last up to 12 months.<sup>4,7</sup>

When the plan outlined above fails, the infant should be referred to a center where parenteral hyperalimentation is frequently employed by experienced personnel. The bow is "at rest" while the patient receives total parenteral nutrition. After adequate demonstration of positive nitrogen balance (significant weight gain), oral feedings are initiated as outlined above and in Table I.

We do not employ antibiotics or anticholinergic preparations unless there are specific indications. Antibiotic therapy can result in the establishment of an abnormal flora which may result in the development of a chronic diarrheal state. Antibiotics are employed when a potentially causative bacterium is isolated on stool culture or if the patient has a proven infection elsewhere, i.e., urinary tract infection, etc. Anti-



cholinergic drugs have many potentially dangerous side effects and are used only in patients with rapid gastrointestinal transit on a chronic basis, i.e., "short-gut" syndrome, etc.

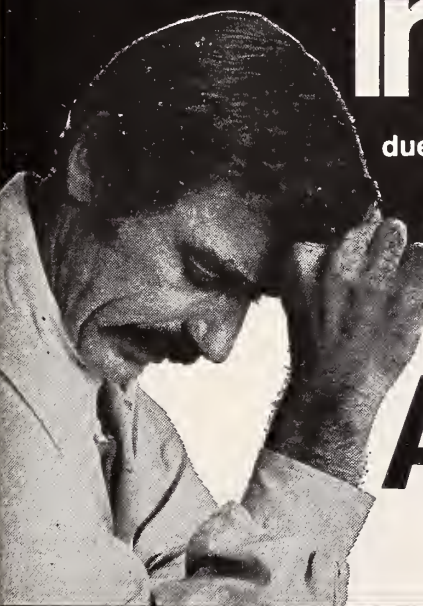
The progression schedule outlined in Table I is rapid enough to prevent significant malnutrition but slow enough to avoid a recurrence of diarrhea in the majority of infants. We strongly feel that this approach to non-specific infantile diarrhea will lessen the likelihood of the development of the dread "protracted diarrheal syndrome of infancy."

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8. Gatorade: Stokley-Van Camp Inc., Indianapolis, Ind. 46204.  
9. Pedialyte: Ross Laboratories, Columbus, Ohio 43216.  
10. Isomil: Ross Laboratories, Columbus, Ohio 43216.  
11. Nutramigen: Mead Johnson Co., 2404 W. Pennsylvania St., Evansville, Ind. 47721.  
12. Similac: Ross Laboratories, Columbus, Ohio 43216.  
13. Enfamil: Mead Johnson Co., 2404 W. Pennsylvania St., Evansville, Ind. 47721.  
14. Bremil: Syntex Laboratories, Inc., Stanford Industrial Park, Palo Alto, Calif. 94304.  
15. Cho-Free: Syntex Laboratories, Inc., Stanford Industrial Park, Palo Alto, Calif. 94304.  
16. Pregestimil: Mead Johnson Co., 2404 W. Pennsylvania St., Evansville, Ind. 47721.




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September 1973

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# ART, HOBBY SHOW PLANNED FOR ISMA ANNUAL MEETING

Space will be provided at the 1973 annual meeting of the Indiana State Medical Association, October 8, 9 and 10 at Indianapolis, for an Art and Hobby Show. Members of the ISMA and their wives are invited to participate. Information regarding this year's show may be obtained from:

Indiana State Medical Association	or	Mrs. Harry Siderys
3935 North Meridian Street		9015 Kirkham Court
Indianapolis 46202		Indianapolis 46260

It will be the responsibility of each exhibitor to see that his work gets to and from the new Indiana Convention-Exposition Center, 100 S. Capitol Avenue, Indianapolis. (The final arrangements will be provided by the committee.)

ISMA will provide suitable display facilities, but each exhibitor is responsible for transportation costs or any other such expenses involved in entering his exhibit.

In order that the committee may do its best in fulfilling the needs of your exhibit, it is ESSENTIAL that you accurately indicate below the amount of space required for your exhibit.

ALL exhibits must be labeled with your name and address and each should be titled.

We do not encourage rare or valuable exhibits since their safety cannot be insured.

In order that the committee may be adequately prepared for your exhibit, ALL applications must be submitted no later than SEPTEMBER 29, 1973.

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\*Please indicate whether your exhibit is oil, watercolor, photography, sculpture, or arts and crafts, etc.



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**Precautions**—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitriptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug, such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

**Adverse Reactions**—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 304431

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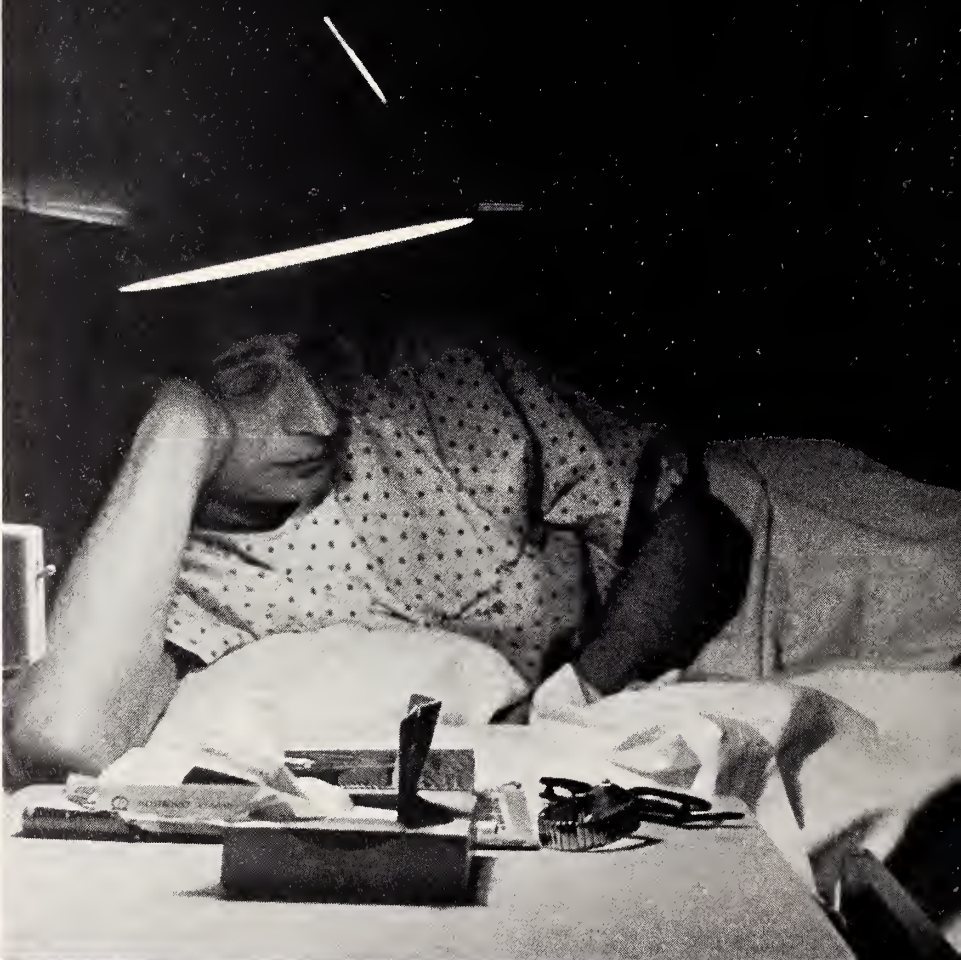
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# Recurrent (Bilocular?) Brain Abscess Due to Unusual Foreign Body — A Case Report

HAROLD E. STADLER, M.D.  
KARL MANDERS, M.D.  
JOHN MARKS, M.D.  
CHARLES BONSETT, M.D.  
Indianapolis

**A**BOUT January 1, 1967, our two-year-old patient, W. K., began to have "episodes of staring" which lasted approximately 6-8 seconds and were accompanied by a questionable facial drooping. The attacks increased to one per hour while awake and she appeared to be dazed following each attack. After a two to three week period she improved though insomnia developed and there was irritability. Approximately one week prior to the onset of the seizure episodes, she had fallen from her bed, which was a distance of about three feet. Crying

endured for about 10 minutes and right frontal swelling was noted. Repeated questioning did not elicit information relative to nasal or aural serous or sanguineous discharge. The past history and familial history were not contributory.

The child was 87 centimeters tall and weight 12.7 Kg. Other than equivocal hyperreflexia of the knee and ankle jerks, the examination was negative. The blood count, BUN, spinal fluid glucose, protein, and cell count were within normal limits. The pneumoencephalogram was negative. Phenobarbital was given in the amount of gr  $\frac{1}{4}$  t.i.d. and she seemed to progress quite well though an occasional minor seizure occurred. An E.E.G. was

done on 3-31-68 and found to be normal.

On about July 1, 1971, the patient developed frontal headache with loss of appetite. The neurological examination was normal except for bilateral papilledema. The E.E.G. suggested a right frontal focus. The brain scan showed uptake in the right frontal area and the presence of a mass in this region was confirmed by a right carotid arteriogram. A craniotomy was performed with the finding of a large well-encapsulated mature brain abscess and this was removed in toto. Coagulase negative *Staphylococcus Aureus* was recovered on culture. The postoperative course was un-

From the Departments of Pediatrics and Neurosurgery, The Community Hospital of Indianapolis, 1500 North Ritter Avenue, Indianapolis 46219.



FIGURE 1

(3-17-72) Ventriculogram, brow upview after injection of radio-opaque material into brain abscess (arrow)

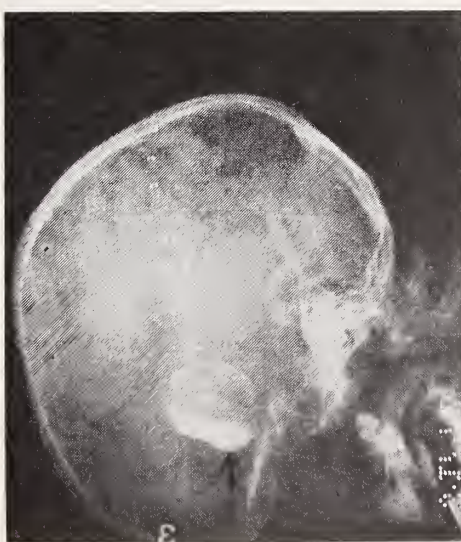


FIGURE 2

(3-17-72) Ventriculogram, lateral view with brow down shows abscess cavity (arrow) filled with contrast media.



FIGURE 3

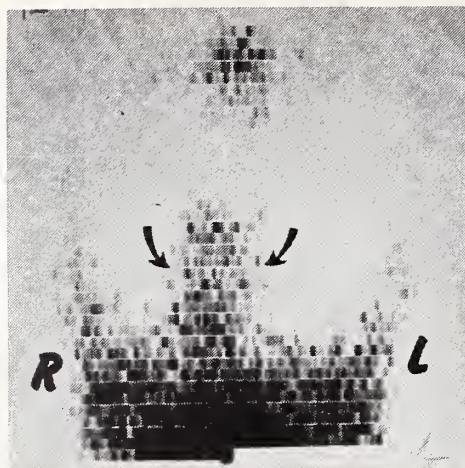
(3-30-72) Tamographic study of the facial area discloses a questionable bone defect (arrow) in the cribiform plate just to the right of the crista galli.





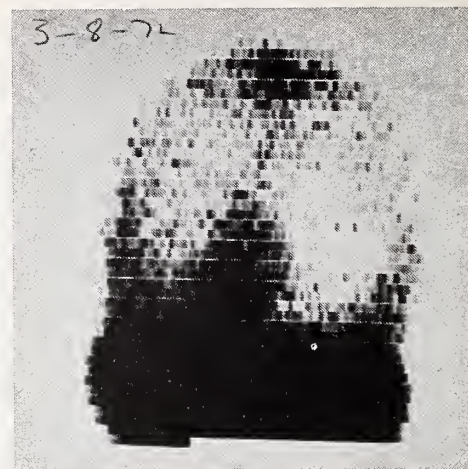
**FIGURE 4**

(July 1971) Right lateral brain scan (99 Tc) shows rather localized area of increased uptake of radionuclide in anterior frontal region.



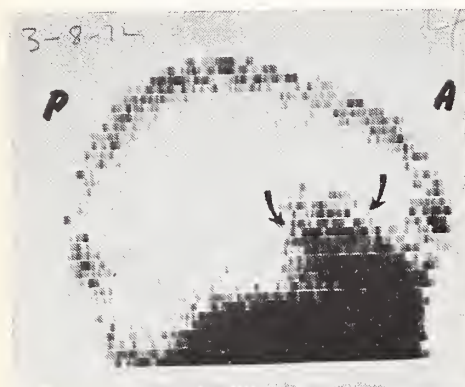
**FIGURE 5**

(July 1971) Frontal brain scan shows increased uptake just to the right of the midline.



**FIGURE 7**

(3-8-72) Frontal brain scan shows increased radioactivity (arrow) just to the right of midline.

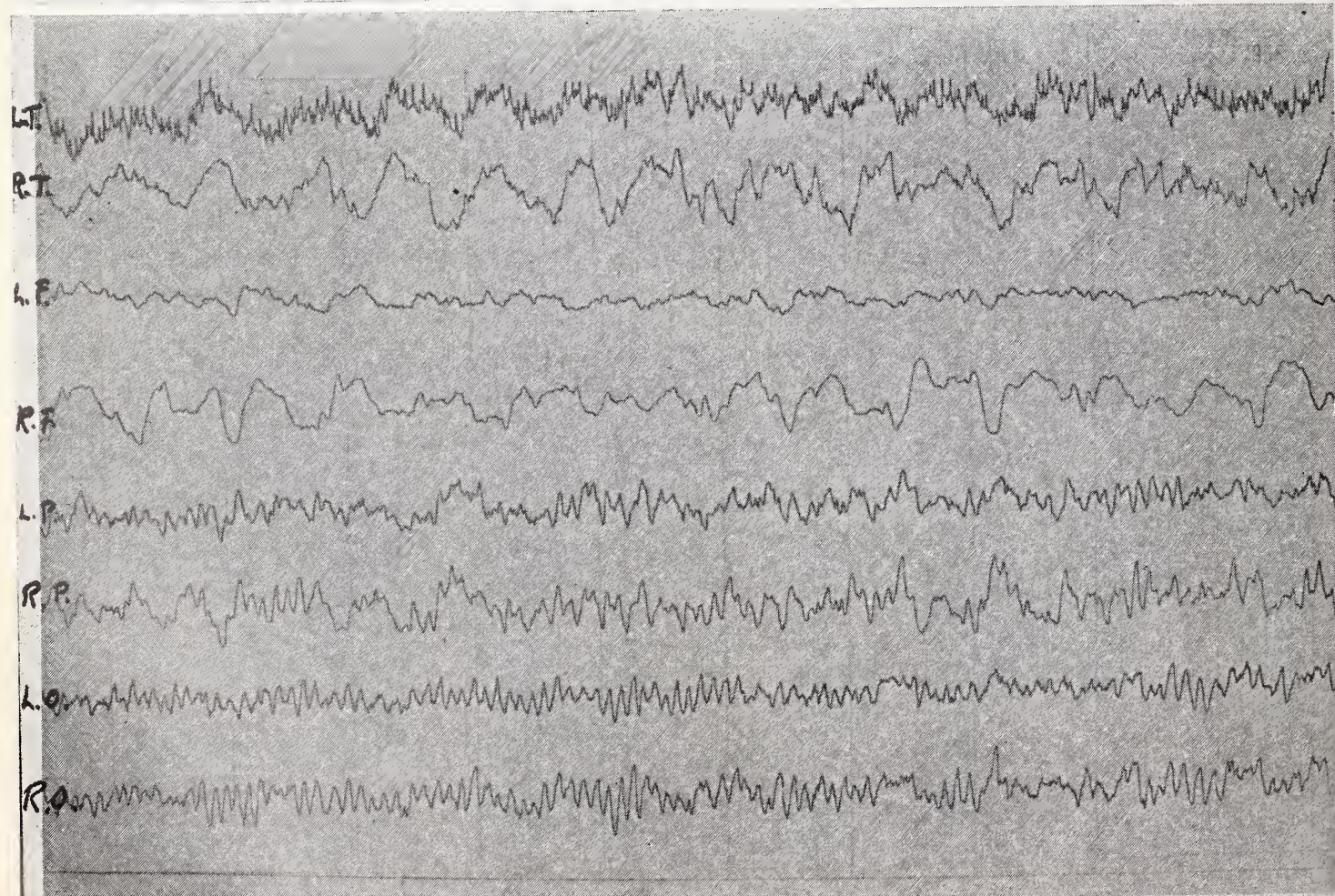


**FIGURE 6**

(3-8-72) Right lateral brain scan (99 Tc) discloses a localized area of increased radioactivity (arrow) in the frontal region posterior to the initial scan of July 1971.

eventful; however, she was treated intensively with antibiotics.

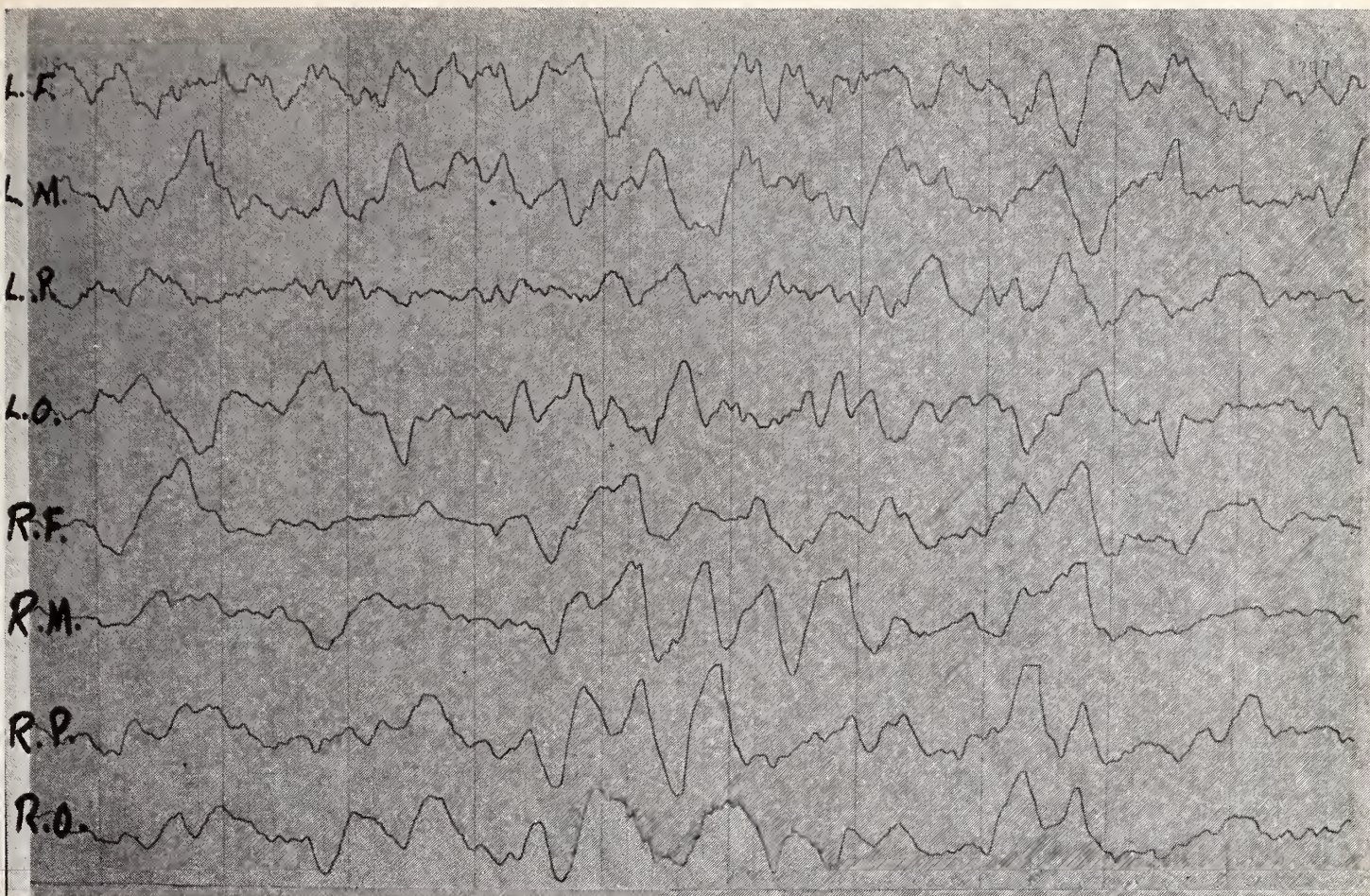
During the first week of March 1972 and for the following 10 days the patient manifested bizarre signs accompanied by three grand mal seizures. Irritability was accom-



**FIGURE 8**

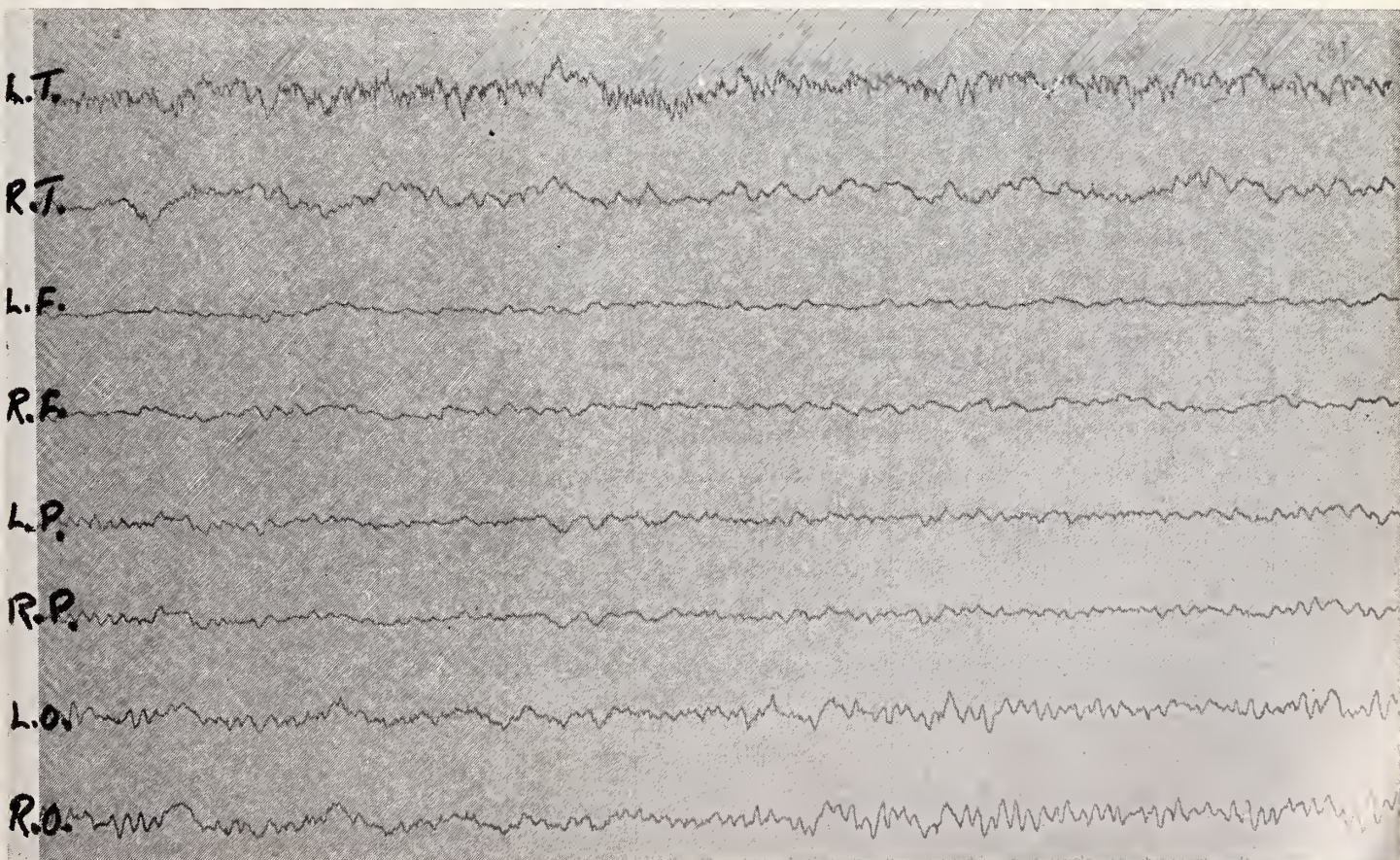
E.E.G. tracing taken 7-14-71. Showing slow wave focus in lines 2 and 4 (right anterior head region).





**FIGURE 9**

E.E.G. tracing taken 3-18-72. Showing diffuse slowing most marked in lines 5 and 6 (right anterior head region).



**FIGURE 10**

E.E.G. taken 4-3-72. Post-surgical tracing. Base line record showing no abnormal features.



panied by increased intracranial pressure with elevation of the right frontal craniotomy flap. She became comatose following a spinal tap but the coma was relieved by ventricular tap. Ventriculogram showed dilatation of the right lateral ventricle and communication to the left was absent. A posterior burr hole was made on the left and the left lateral ventricle was studied and found to be moderately dilated and not communicating with the right. While attempting to do a positive contrast ventriculogram from the right side the abscess cavity was encountered and filled with Conray. The abscess was found to be posterior to the previous location, rising between the two hemispheres (occluding the foramen of Monro) and causing hydrocephalus. The old craniotomy site was reopened on 3-23-72 and the abscess was removed. The post-operative course was smooth; the



FIGURE 11

The specimen of brain tissue is shown with removed pencil tip and scribbling of the contained graphite.

child was treated with antibiotics and anticonvulsants for a period of three months. One month after surgery the child appeared well.

Pathology: "The specimen is a nodular mass of red tissue which measured 2 cm in diameter, and is quite firm and showing a central cystic area. This cystic area contains a cone-shaped dark fragment measuring 1 x .3 x .3 cm with the appearance of graphite and partial-

ly enclosed by a wooden shell. Microscopically the periphery of the nodule showed some brain tissue. The abscess wall is composed of hyalinized tissue containing granulation-like tissue with large numbers of macrophages."

Comment: We are reporting an instance of interfrontal lobe abscess in a two-year-old girl which is of recurrent or possibly bilocular nature. It is quite likely that a pencil was driven through the cribiform plate with the terminal centimeter of the pencil being driven or gravitating to the area of the abscess. It is rather amazing that no spinal fluid leak occurred and that there was no bleeding in spite of injury to the cribiform plate (x-ray #3). Long delayed abscess formation at the site of intracranial foreign body is well-known and has been reported generally but not with the type of foreign body herein described. ◀

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# The Gravlee Jet Washer—An Evaluation

W. R. ANDERSON, M.D.

Bloomington

EDNA PIXLEY, M.S.

Iowa City, Ia.

## Introduction

The Gravlee jet washer presents a new technique for obtaining cytologic specimens from the uterine cavity. The use of negative pressure is unique and obviates potential transtubal dissemination of cells. Techniques used to obtain endometrial cytologic specimens have met with variable success. The major problems with previous techniques (aspiration, brush, and lavage) were incompleteness of the sample, endometrial damage or irritation, and, with positive pressure lavage, the possibility of transtubal dissemination of tumor cells. The jet washer negative pressure technique as developed by Gravlee<sup>1</sup> for use in obtaining endometrial cytologic specimens potentially obviates these problems.

Initial reports by Gravlee have indicated a high degree of accuracy in detection of endometrial malignancy.<sup>1,2</sup> Accuracy was established by independently comparing cytologic and tissue preparations obtained with dilatation and curettage. Using the jet washer technique micro-tissue fragments have been obtained in many cases which on regular paraffin sectioning have been adequate for definitive histologic diagnosis.

To gain experience with this technique, we have performed 100 aspirations using the Gravlee apparatus prior to curettage or hysterectomy. The jet washer specimen and tissue specimen were independently reviewed and compared. This study was conducted at the University of

Iowa Hospitals, Department of Gynecology and Pathology, Iowa City, Iowa.

## Method

Specimens from anesthetized patients were collected in the operating room. An initial pelvic examination was performed to determine pelvic pathology and uterine position. The cervix was then visualized and a single tooth tenaculum applied to the anterior lip of the cervix. A uterine sound was inserted

into the uterine cavity to determine depth and to dilate the internal cervical os. The adjustable acorn on the washer nozzle was positioned so that the tip of the nozzle would be 1-2 cm from the top of the fundus. A disposable 50 cc syringe was attached to the appropriate aspirating terminal and the other terminal was placed in an Erlenmeyer flask filled with sterile saline. Thirty cc of saline was drawn through the jet washer apparatus and collected in the disposable syringe. The syringe was disengaged and filled to 50 cc

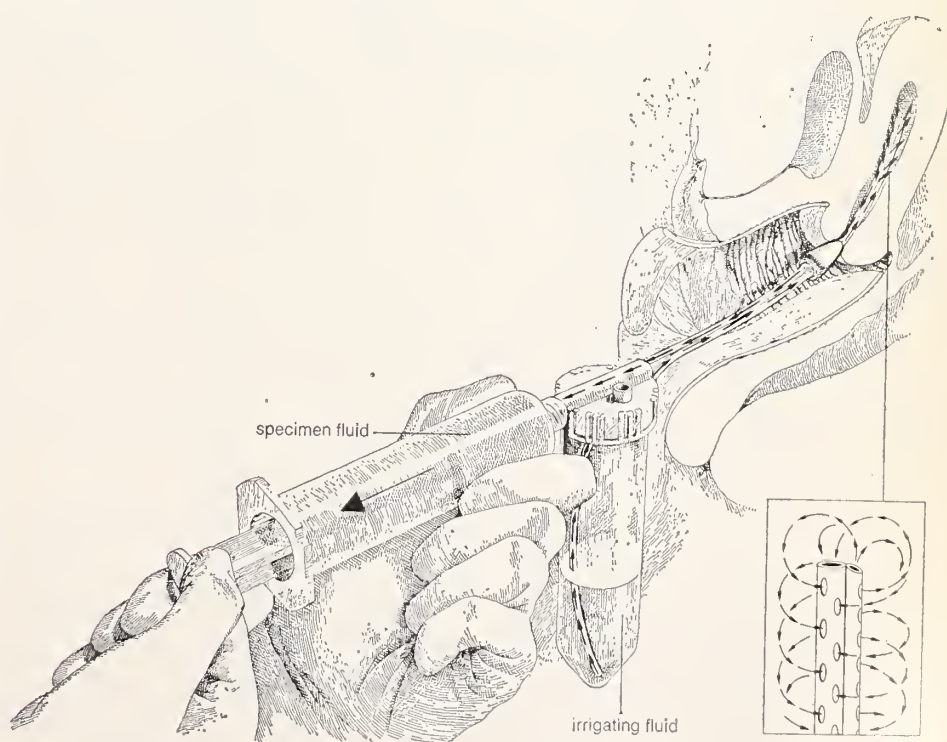


FIGURE 1

## The Gravlee Jet Washer

Irrigating fluid is transmitted to the uterine cavity and into the syringe by the negative suction which is created by the syringe. The swirling action of the fluid in the uterine cavity dislodges cells which are aspirated into the syringe. No positive pressure is created within the uterus.



with buffered formalin. A plastic cap was placed over the tip, and an identifying tape used to hold the syringe and plunger stable, effectively entrapping the specimen in the syringe. Specimens were collected daily and immediately delivered to the cytology laboratory. The specimen was filtered through a 5 micron Millipore filter at a constant negative pressure not exceeding 100 mm of mercury, a technique described in Millipore's 1969 Application Report AR-24.<sup>3</sup> Pieces of tissue identified on the Millipore membrane surface were selectively removed and sent to the tissue laboratory for paraffin sectioning. Papanicolaou staining and preparation for cytologic examination was carried out. Systematic screening of the membrane preparations was done at 10 and 45 magnifications.

The paraffin specimens were reviewed in conjunction with the cytologic membrane specimens, and a diagnosis of malignancy, atypical cells—possibly malignant, or no abnormal cells was assigned to each specimen. The tissue sections from the surgical specimen were *independently* reviewed by two examiners with review and correlation of material at the completion of each 25 specimens. The procurement of specimens was performed by senior and junior staff physicians after appropriate instruction in the jet washer technique. They experienced no difficulty in learning the proper technique.

Results

The results are summarized in Table 1. The specimens were found to be uniformly well fixed and presented no problems in preparation. Only two specimens were considered unsatisfactory on the basis of lack of cytologic material. Of the two cases thought to have insufficient cellular material, one was subsequently found to have an endo-

Table 1	
RESULTS	
93 — Accurate Reports	
2 — Insufficient Material	
1 — False Negative	
4 — False Positive	
100	Total Cases

metrial adenocarcinoma at the time of hysterectomy; but dilatation and curettage immediately preceding the hysterectomy failed to reveal gross evidence of malignancy. The second insufficient specimen had atrophic endometrium at curettage. Our criteria for a report of insufficient specimen material was the absence of identifiable endometrial cells.

One false negative case was recorded. This premenopausal patient had a well-differentiated secretory adenocarcinoma of the endometrium. The Millipore membrane cytology was interpreted as no abnormal cells, and normal secretory cells were present. The companion paraffin section had small fragments of abnormal secretory cells and several glands, but this tissue was not deemed adequate to justify a report of malignancy.

Four positive reports were given when no malignancy was found. In one case a postmenopausal woman was on estrogen therapy, and in another case severe cervical dysplasia was diagnosed on cervical conization. Two cases had abnormal cells present and no curettings were obtained for pathologic review at the time of curettage.

Ninety-three specimens correlated with the pathologic findings. Eight cases of endometrial adenocarcinoma were correctly diagnosed. Two cases of atypical endometrial hyperplasia were suspected and confirmed by review of the curettage specimen. Many specimens contained tissue fragments which on paraffin sections represented micro-biopsies with enough tissue to allow a definitive pathologic diagnosis. Six of the eight cases of endome-

trial carcinoma had a definitive diagnosis on the paraffin section of the jet washer fragments. Twenty-three other cases had enough tissue present on the paraffin section to allow histologic dating and interpretation of the endometrium.

Following completion of this series of 100 patients, the opportunity to observe the fallopian tubes while using the jet washer negative pressure technique has been afforded by use of simultaneous laparoscopy. In four consecutive cases, saline stained with methylene blue has been used with the jet washer procedure while maintaining visual laparoscopic control of the pelvic structures. *In all cases no evidence of tubal transport of the methylene blue solution occurred with the jet washer apparatus.* In all these cases follow-up tubal patency was established visually by dye passage using positive pressure.

Discussion and Summary

Our experience with the Gravlee jet washer apparatus has yielded satisfactory results, comparable to the results obtained by Gravlee.<sup>1,2</sup> We have had very few unsatisfactory specimens (only 2) as noted in the initial publication. The maintenance of cervical blockage during the jet spray procedure and immediate fixation of specimens may have decreased the number of unsatisfactory specimens. Contamination with squamous and endocervical glandular cells was noted frequently in our series. If no identifiable endometrial cells were present in the cytologic specimen, a report of insufficient cells was the appropriate observation.

Interpretation of the jet washer specimens was made with only the patient's name, age, and hospital number. Knowledge of the clinical history, particularly the use of exogenous hormones, previous pelvic irradiation, and temporal relation-



ship to ovarian cycle would aid considerably in increasing diagnostic accuracy.

We feel that the potential accuracy and safety of this technique in assessment of the endometrial cavity warrants its use in several clinical situations. Our primary area of concern is the valuation of asymptomatic women in an increased risk category for endometrial cancer (age greater than 40-45). Gravlee has already reported the successful use of the procedure as an outpatient procedure.<sup>2</sup> We have limited experience thus far in the unanesthetized patient, but have encountered difficulty in several

cases of relative cervical stenosis. There has been uniform patient acceptance of the procedure in the absence of cervical stenosis.

Another appropriate area for use of the jet washer is following curettage in the asymptomatic patient from whom no tissue is obtained. In evaluation of the symptomatic patient the jet washer may be of help in providing fragments of tissue for definitive diagnosis or suggesting malignancy cytologically. With pre-operative information the surgeon and radiotherapist can preplan care for the patient with a single anesthetic.

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2. Gravlee, Clark L.: Jet-irrigation method for the diagnosis of endometrial adenocarcinoma — its principle and accuracy. *Obstet. Gynec.* 34:168, 1969.
3. Millipore Exfoliative Cytology, Application Report AR-24, Catalog No. LTAR 024 BA, Copyright Millipore Corp. 1969.

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## INDIANA STATE BOARD OF HEALTH MONTHLY REPORT JULY—1973

DISEASE	July 1973	June 1973	May 1973	July 1972	July 1971
Animal Bites	1413	1849	1038	1345	1445
Chickenpox	122	536	715	123	96
Conjunctivitis	304	252	336	205	282
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	34	33	27	22	46
Gonorrhea	686	1291	796	866	834
Impetigo	259	125	112	182	176
Infectious Hepatitis	45	64	41	51	42
Infectious Mononucleosis	35	55	59	44	42
Influenza	1063	1433	1310	688	820
Measles					
Rubeola	59	60	100	37	135
Rubella	21	69	153	44	103
Meningococcic Meningitis	0	2	1	0	1
Meningitis, Other	0	2	1	0	6
Mumps	83	82	151	50	150
Pertussis (Whooping Cough)	2	2	1	10	13
Pneumonia	297	467	545	213	286
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	738	1276	1469	708	580
Syphilis					
Primary & Secondary	12	28	17	17	44
All Other Syphilis	65	127	84	93	125
Tinea Capitis	8	8	5	2	0
Tuberculosis (Active)	53	80	75	35	60



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*The Journal* welcomes the following physicians who have become members of the Indiana State Medical Association and the county society listed since the publication of the Roster of Members in the June issue:

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Indiana Bank Bldg., #725  
Fort Wayne 46802

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401 East Flora  
Washington 47501

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Warsaw 46580

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Gary 46408

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South Bend 46617

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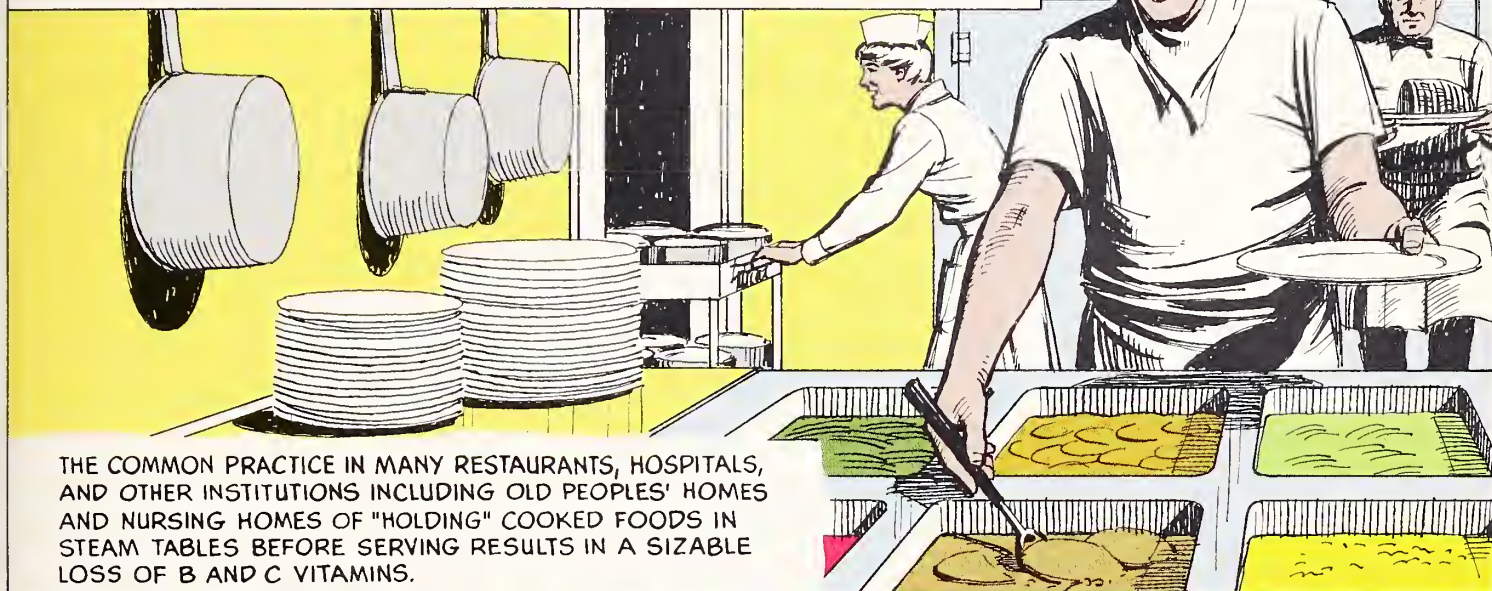
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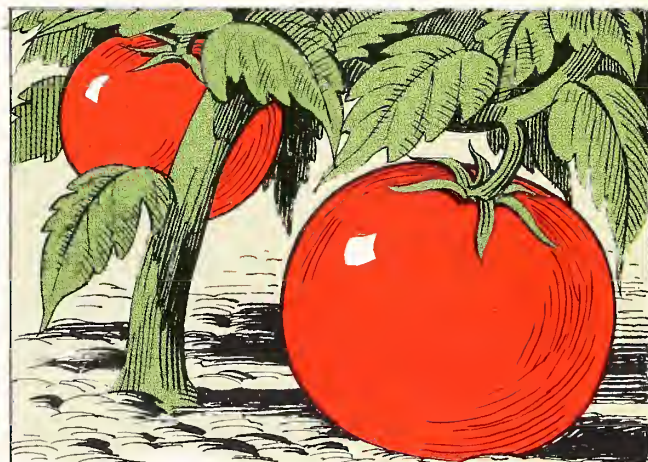
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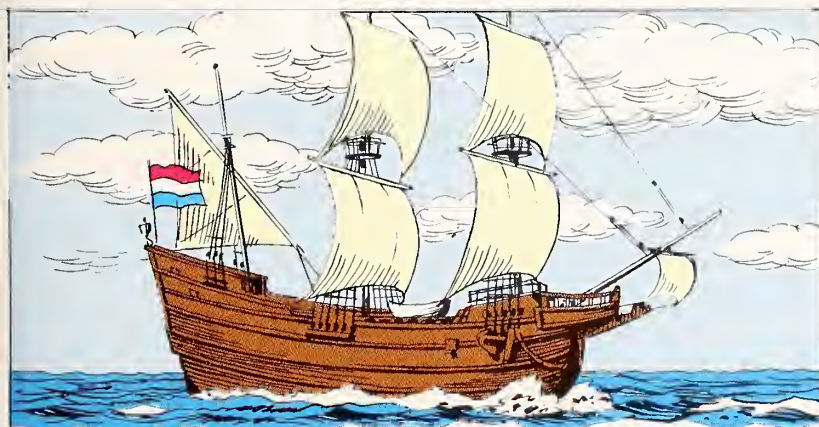
THE COMMON PRACTICE IN MANY RESTAURANTS, HOSPITALS, AND OTHER INSTITUTIONS INCLUDING OLD PEOPLES' HOMES AND NURSING HOMES OF "HOLDING" COOKED FOODS IN STEAM TABLES BEFORE SERVING RESULTS IN A SIZABLE LOSS OF B AND C VITAMINS.



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THE AMOUNT OF SUNLIGHT AVAILABLE DURING RIPENING DETERMINES TO A LARGE EXTENT THE FINAL ASCORBIC ACID CONTENT OF TOMATOES. HENCE, A COOL, WET SUMMER PRODUCES WATERY, LESS TASTY FRUIT THAT'S LOWER IN VITAMIN C.



RONSENS, A DUTCH PHYSICIAN, WROTE IN 1564 THAT "DUTCH SAILORS WHO, RETURNING FROM SPAIN, WERE ATTRACTED BY THE NOVEL RICHNESS OF THE FRUIT (ORANGES) AND BY THEIR GREED AND GLUTTONY, UNEXPECTEDLY DROVE OUT THE DISEASE (SCURVY), AND HAD THIS HAPPY EXPERIENCE NOT ON A SINGLE OCCASION ONLY, BUT REPEATEDLY."

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## Guest Editorials

### Health Care In Sweden- Condition Deteriorating

THE scene is a typical hospital in Sweden. Exhausted hospital personnel are processing long lines of patients. Some of them waited years for elective medical care. This is the bleak picture of health care in Sweden painted in a series of articles printed earlier this year by Expressen, Sweden's largest daily newspaper.

People in Sweden are not permitted to choose their doctors or hospitals. They must go to the hospital serving the district where they live. Under Sweden's "seven crowns reform," which began about two years ago, a patient pays a flat rate of seven crowns (about \$1.50) for a doctor's visit or hospitalization. All private institutions, private doctors or medical clinics are excluded from this flat rate, and entirely different regulations cover dentistry.

In its series of articles, Expressen zeroed in on several people who had been entrapped in the bureaucratic web of Sweden's socialized medicine:

Anna-Britta Eriksson, 40, of Goteborg, had been waiting for 10

years to have a gallstone operation. Shortly after her gallstones were discovered, she moved from Sundsvall to Goteborg. Several years later when her gallstones again gave her difficulty, an operation was scheduled for one week later. However, this was postponed when the hospital discovered it had forgotten to obtain her X-rays taken earlier in Sundsvall. A year later the hospital phoned and said the operation had been rescheduled for the next morning. Mrs. Eriksson was unable to plan to enter the hospital on such short notice and asked that the operation be postponed and that she be given more notice the next time. At the time the story was printed, Mrs. Eriksson had not heard from the hospital again, and her chronic gallstone ailment was being treated with various medications and diet.

Pia, 24, had suffered from a thyroid enlargement. When this condition flared up again, she found herself without medication. The hospital in Sabbatsbergs told her there was a half-year waiting time to be examined. Next she phoned her old family physician, but he had moved. After obtaining a requisition from the district physician, she waited four months for the first examination. Laboratory tests were scheduled for many months later. After

nine months and a weight reduction from 107 to 96 pounds, Pia finally got her medication.

A 52-year-old Vasteras laborer had been suffering from diminished visual acuity and watering eyes. He was told he could come in for an eye examination "in about a year." According to the chief physician in the ophthalmological clinic, the waiting time for new patients is 14 months. Waiting time for eye operations is one to two months, and this time cannot be shortened, even if desirable.

In Sweden the chance to survive often depends on where one lives, a physician told Expressen. In a survey of 29 hospitals throughout the country, Expressen found lines of patients everywhere. Sometimes waiting times ran into the years. Less urgent cases often were not examined at all. However, in emergency cases care is given expeditiously.—*Journal of the Medical Association of the State of Alabama. Reprinted with permission.*

### This Is No Time to Become Cynical

WE in the business community need to maintain a wholesome perspective and positive at-



titute with respect to the Watergate revelations.

They are shocking, of course. Much is being said about the effect on the ability of the President to govern effectively, and the slowing down of government machinery. These are valid concerns.

If the Watergate scandals reveal weaknesses in our popular government, they also reveal its chief strength: The built-in correction mechanism of our separation of powers. No other system has it. Our political system can meet this crisis, as it has many others.

This is no time to become cynical. Much good may come of Watergate. Historically, curative action has followed revelation of our faults.

Government must go on.

In world affairs, we must maintain our leadership and our security.

At home, there are many challenges begging for imaginative solutions which the enterprise system can provide in a conducive climate.

The Administration must not let Watergate dilute its effort to provide good management and seek sound approaches to national and community problems.

We the people must not let Watergate undermine the first real opportunity to modernize our government and improve control of spending and management of our Federal Government.

We in business must rededicate ourselves to participate constructively in the political process.

With respect to persons hit by the scandals, all of us must determine to keep an open mind until all of the evidence is in. **Arch N. Booth, Chief Executive Officer, Chamber of Commerce of the United States, Washington, D.C.**

## Editorial Notes . . .

**One of the specious arguments advanced in favor of repealing the**

**anti-substitution pharmacy regulations is that such an action would relieve the retail pharmacist of the burden of maintaining unnecessarily large inventories.** A Pharmaceutical Manufacturers Association survey, however, shows that most retail pharmacists stock slightly over 33 products to fill prescriptions for the 10 most prescribed generic medicines. Most of the pharmacists surveyed said that the availability of multiple brands of prescription drugs has not created a serious inventory problem.

**Carbon monoxide poisoning occurs in non-smokers in a smoke-filled room.** English investigators show that carboxyhemoglobin levels rise from 1.6% to 2.6% in non-smokers as compared to an 0.7% rise in smokers per cigarette smoked.

**High temperatures early in the Skylab flight prompted NASA to inquire from the Pharmaceutical Manufacturers Association regarding the durability of drug preparations under unexpectedly warm conditions.** Due to the fact that pharmaceutical makers conduct accelerated shelf-life studies on most drugs they were able to furnish reliable information. Some of the skylab drugs were stable, some required replacement.

**Some pharmacists advocate having the M.D. make the diagnosis and assigning the choice of drugs to the pharmacist.** A recent paragraph in a column by Robert F. Steeves in DRUG TOPICS for July 16, 1973, is as follows: "Both the decisions and the regulations bring the day closer when the physician will diagnose the physical and physiological condition of a patient, provide raw medical data, and establish priorities and objectives for patient care—leaving drug therapy to be deter-

mined either in whole or in part by a pharmacist."

**In 1969 the American Pharmaceutical Association advocated repeal of the state anti-substitution laws and regulations.** Since then two states, Missouri and Alaska, which had no state anti-substitution laws have adopted them. No states have repealed their anti-substitution laws or regulations. Four states, Massachusetts, Maryland, Kentucky and New Hampshire, have adopted some version of pro-substitution legislation weakening their anti-substitution regulations. Actually, little except expense to these states has occurred in their efforts to promote the interchange of cheaper drug products at the option of the pharmacist.

**The Metropolitan Life Insurance Company reports that persons who have been treated for cancer may be selectively hired for positions for which they are physically qualified and that their work performance differs little from that of others hired at the same age for like assignments.** Company expense was not noticeably increased by excessive absences, reduced productivity or increased mortality.

**"Environmental and Public Health News" reports that copper-containing IUDs may prevent their users from contracting gonorrhea.** Investigators have found that small amounts of copper will inhibit the growth of gonococci and destroy them in about 30 minutes.

**Sulfur dioxide and particulate matter pollutants have decreased in some cities in the past 10 years.** Particulate matter is down by 20% and sulfur dioxide by 50%. The improvement is thought to be due to the increased use of low-sulfur fuels.



# PSRO: The Doctor Must Lead the Way

ROBERT M. REID, M.D.  
Indianapolis

**D**URING the past several decades, physicians, have witnessed an increasing public awareness of health matters. The population has been educated to recognize its needs and has attempted to define its rights. The "third party" insurance carrier has become a fact of life—accepted as an important, if sometimes aggravating—participant in the economy of medicine. Each year has brought new, more far-reaching, proposals for increased governmental involvement.

We have watched Task Forces, Presidential Commissions and Congressional Committees become instant experts on what's wrong with American medicine and what should be done about it. Our medical organizations have participated at various levels in the development and analysis of some of these efforts. We regularly have urged caution in the headlong approach to broader governmental participation, painfully pointing out the problems that could be anticipated. More often than not, when such programs were undertaken in spite of the advice of the physician, the responsibility for the very same problems was laid squarely at his door.

Too frequently, public attention has been focused on relatively isolated physician deficiency. Health delivery limitations attributable more to economic than medical factors were emphasized. The result has been an emotional outcry which usually managed to present the doctor as the primary culprit. Politicians, prompted by the news media, have attempted to identify and publicize the problem areas. Somehow, when the approach to a solution is offered, the rhetoric of the remedy

is phrased more in terms of individual rights than responsibility. The suggestion that a current social problem—medical or not—may reflect some failure of individual initiative characterizes the spokesman as callous and indifferent to public need. The prevailing attitude seems to be that if the problem exists it must be the fault of the institutions involved, and the government should do something about it.

Frustrated, and often bitter in the face of these developments, the doctor generally has persisted in his deep-rooted belief in the importance of maintaining the essential elements of the traditional doctor-patient relationship—and the mutual motivational factors that relationship implies. Generally, when new programs are instituted over his objection, he attempts to participate in trying to make them work. He will spend many hours, without reimbursement, in helping to administer programs with which he has fundamental disagreement—as in the case of Medicare. Regularly, because he is the one who deals directly with the public, he is the "fall-guy" in the patient's eye when the coverage is less than expected. The doctor remembers—and remembering adds to his apprehension about the next legislative step.

Now, again, we must face that step taken in the name of Professional Standards Review Organizations as a part of PL 92-603, passed in October 1972. At the first glance, this looks like the worst one yet. Many physicians already have expressed their understandable objections to it. This law promises to protect the public by passing judg-

ment on the appropriateness and the quality of the medical care in which the government holds some responsibility for payment. Painfully aware of the federal track record in administering this type of program, many doctors have reacted by saying, "Hell, no—not this time. Let them do it themselves. We can't win anyway, the politicians will take credit for anything good that comes from it; and they will give us the blame for all the bad things." In view of past experience, no doctor has to look back very far to understand and sympathize with this attitude.

My purpose in writing this article is to urge a bit of extra care in the examination of this new law. Careful study will show that this is a different breed of cat from Medicare and Medicaid, etc. Whatever their shortcomings, the latter programs are in effect, and public money is being used to pay for medical care. The politician, ever sensitive to public reaction—and hopefully influenced by some degree of common sense, has acknowledged that only the physician is able to make the ultimate decision as to the appropriateness or quality of patient care. This is carefully set out in the law. Public support has been, and will continue to be, our best weapon in preserving the optimal medical environment for the patient. If we oppose this legislation without qualification, we appear to be saying that the government does not have the right to know that it is getting its money's worth from us—even if it permits the practicing physician to make the judgment and pays him for his effort. It is hardly likely that



the public will support that position. A "hands off" attitude will seem to confirm the worst accusation made against us.

It has been suggested that we should approach the legal vulnerability of this new law—possibly with a class action suit. Perhaps this would accomplish some stalling of the implementation. It should be remembered, however, that with the prevailing public attitudes and the apparent fairness of this legislation, the lawmaker is in a position to circumvent our maneuver with modifications that could be even more untenable. There can be no doubt the public will support the basic concepts the law incorporates. It will remain the law.

If we can assume that this is a realistic approach, then we are forced to examine the law itself. What really is wrong with it? Much already has been written but I believe the basic problems can best be summarized by reference to the reporting structure the law incorporates. The carefully worded provision for required physician judgment is limited essentially to decisions regarding the acceptance or rejection of an individual clinical case. In the early stages—in the absence of significant data for national or regional comparative evaluation—there will be considerable freedom for the participating local physician in utilizing his own unfettered judgment. The law, however, recognizes its ultimate intent to establish much broader norms for comparison—and relates to provisions for reporting structures to develop this type of data. In my opinion, therein lies the rub—and the opportunity.

It is safe to guess, I think, that no one—particularly HEW personnel—knows at this date what type of data should be reported or how it should be used. Such critical considerations as control of access, the definition of the decision makers

and the limits to the use of the data have not yet been worked out. The data in reference is largely physician-generated. Granting that there are areas of appropriate governmental interest in such data, it should be obvious the custodianship of this kind of material will demand very sophisticated judgment with respect to availability and use of it. The public has traditionally trusted the medical profession in the handling of their highly sensitive, confidential medical data. I believe the public expects us to continue to exert very rigid control over the information which they provide us. The inevitable progress in the technology of patient data accumulation and storage will continue to emphasize the importance of our awareness in this matter.

History would suggest that we will not have much success in changing the structure of the law itself. We will not have much influence at the top of the system—but we certainly can affect it at the bottom, or at the point of data entry. The doctor must become knowledgeable in the manner of collection, storage and processing of patient data. He must build in restraints as to the use of his data before he yields it to *any* agency. This is an absolutely proper exercise of discretion by the physician—he has to be willing to stand and fight on this issue. Once the public understands it, they will support his position on this.

You may possibly say: "What do you mean, once the public understands it? I don't even understand it!" I say to you: "Doctor, you had better be prepared to determine what you feel is appropriate dissemination of data concerning *your* patient. The alternative is to have the federal agencies define, by regulation, what that content will be." You might reply: "Well, maybe I agree with you but I don't know

how to build in all those restraints on the use of my data." This introduces the most critical factor in this discussion. The doctor—in alliance with the other health professionals—must lead the way in establishing his own data processing facilities. He must begin to be informed as to the proper use—and potential misuse—of this kind of material. Accomplishing this end will require the utilization of data processing expertise responsible to him—and to him alone.

Such efforts involve expense. No local physician group can accommodate to ongoing investment that such a program will demand even with the anticipated federal subsidy. It is for this reason that I urge doctors not to allow themselves to be fragmented in this effort. If you want to make an effective response to these requirements for standards review, build your organizations on the highest possible level—state or higher. This is one time when the exercise of local pride could be fatal for us and our patients. Almost any hospital or institution with a computer would be happy to offset some of their fixed expenses by modifying their claims processing programs to such use. The old appeal for "keeping it at home where we can manage it" may sound good but it won't work for long here. HEW can be expected to encourage the proliferation of such small "regional" programs. In that manner, they will be in a position to dictate, absolutely, the mechanics of the reporting structure. No single agency will have the volume to refute their figures or challenge their methods—and they will retain the weapon of threatened withdrawal of coverage for enforcement. Ironically, the federal agencies need not have any malicious intent in order to create this dilemma. It is inherent in the system.

If the doctor and his associates can react effectively in this area, he



will have accomplished a number of objectives. He will have attained equal, if not superior, status with any federal agency in establishing and evaluating norms to be used in the review of *his* work. He will have made a beginning in the establishment of a clinical data repository, the potential benefits of which will far exceed those of standards review in terms of research and patient

service applications. Most importantly, he will have met his traditional obligation to control the data generated by—or for—him about his patients. He must be prepared to defend inappropriate access to this material against *anyone*. The technology of data processing can make this feasible.

Gentlemen, if we respond to this

challenge openly—and with pride rather than apology—we can actually assist in administering a program that is justifiable in concept. At the same time, we will have met our requirements as physicians to protect the patient's interest and confidence.

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### From *The Journal* 50 Years Ago

**Chronic Sinusitis:** Treatment of chronic sinusitis in the absence of complications or urgent symptoms depends to a great extent on the individual. In individuals to whom it is a disadvantage to continue local treatment, radical measures are necessary. The indications in treatment are to facilitate drainage and to restore the mucous membrane to the normal state. Establishment of drainage may necessitate the removal of hypertrophies of the turbinate bones, removal of nasal polyps, or the straightening of a deviated nasal septum. With proper drainage and ventilation of the sinus cavity established, the purulent process will gradually disappear. Catheterization of the ostia and thorough lavage of the sinus will in some cases effect a permanent cure. Suction of the secretion from the sinus has been advocated by some authors. When the nasal mucosa has been shrunk and the sinus ostia opened as far as possible, negative pressure is applied to the nares and the patient asked to pronounce the letter K. The suction thus applied will draw considerable secretion from the sinus. If after a proper time results are not obtained by these methods of treatment, or if complications ensue, radical operative measures are necessary. These measures have for their purpose establishment of permanent drainage of the sinus or the total exenteration of the sinus. The detailed steps of these operative procedures are too lengthy to be discussed in this paper. Vaccine therapy has been questionable. There is practically always a mixed infection and it is impossible to say which organism is the chief cause. An autogenous vaccine, if a pure culture can be obtained, is of value. Vaccines may be tried in persistent mild cases that do not warrant operation, or as a part of the after-treatment following operation . . . Samuel M. Baxter, M.D., New Albany, "Infections of the Nasal Accessory Sinuses," *JISMA* September 1923.

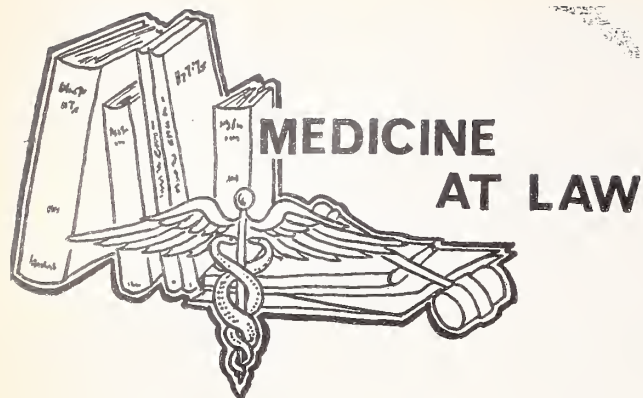
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**Commitment of Person Incompetent to Stand Trial**—Subjection of an accused person who was found incompetent to stand trial to a more lenient commitment standard and a more stringent standard of release than those applicable to persons not charged with offenses deprived him of equal protection of the law, the U.S. Supreme Court ruled.

A mentally defective deaf mute who could not read, write, or otherwise communicate except through sign language was charged with two criminal offenses. Psychiatrists who examined him reported that his condition precluded his understanding the nature of the charges against him or participating in his defense. They said that even if he were not a deaf mute he would be incompetent to stand trial and that he did not have sufficient intelligence to enable him to develop communication skills.

The court ordered the accused committed until such a time as his sanity could be certified. A motion for a new trial was denied, and the state supreme court affirmed. The U.S. Supreme Court granted certiorari.

The counsel for the accused contended that his commitment was tantamount to a life sentence without conviction of a crime and that such commitment deprived him of equal protection. If there had been no criminal charges against the accused, the state would have had to proceed as for the feeble-minded or

the mentally ill. In such case, the accused would have been entitled to substantially greater rights.

The Supreme Court found that indefinite commitment of an accused person solely because of his lack of capacity to stand trial violated due process. The court held that if it was determined that the accused would not attain competency in the foreseeable future the state must either institute civil proceedings for indefinite commitment of those charged with crime or release him. *Jackson v. State of Indiana*, 92 S.Ct. 1845 (U.S. Sup. Ct., June 7, 1972).

*Editor's Note:* A prior decision was reported in *THE CITATION*, Vol. 21, No. 4, p. 64.

**Surgeon Recovers Damages for Automobile Accident Injuries**—An award of \$23,000 in damages to a surgeon who suffered permanent paresthesia as a result of an automobile accident was held by an Indiana appellate court not to be excessive.

The surgeon was injured when his automobile was struck from the rear by a driver who failed to stop for a traffic signal. His injury was diagnosed as a sprain of the cervical spine, resulting in nerve irritation with resultant paresthesia in his right forearm and hand.

The paresthesia frequently caused a tingling sensation in his fingers, which was expected to be permanent. The surgeon suffered from re-

curring low-voltage electrical shocks and managed to discipline himself to scrubbing, changing clothes, and operating without reacting to them.

The surgeon brought action against the driver of the other automobile to recover damages for his injuries. The jury awarded him damages of \$23,000, and the other driver appealed.

The driver complained on appeal that the damages awarded the surgeon were excessive. The court had instructed the jury that in determining the amount of damages it should add nothing because of sympathy for the surgeon or as punishment for the driver.

The appellate court found that such cautioning of the jury was adequate. Further, the court said that it could not interfere with the jury's award unless the damages were flagrantly outrageous. Affirming the judgment of the trial court, the appellate court said that \$23,000 was not excessive for the permanent suffering that the surgeon would have to endure while performing his professional duties.—*Bonek v. Plain*, 288 N.E.2d 185 (Ind.Ct. of App., Oct. 24, 1972).

**Patient Slips and Falls in Clinic Parking Lot**—A clinic that provided free open-air parking for patients was not under a duty to remove natural accumulations of ice and snow from the parking lot, an Indiana appellate court ruled.

After an inch of snow fell, the clinic parking lot was plowed and salted. Snow fell on the following day and again two days later. On the last day of the snowfall, a patient slipped and fell on the ice in the parking lot while on the way to her car.

The patient brought action against the clinic, alleging that it was negligent in failing to maintain the lot in a safe condition, in permitting ice and snow to accumulate and failing to remove it, and in failing



to warn her that the lot was unsafe. The trial court entered judgment for the clinic, and the patient appealed.

The appellate court cited a previous decision where it was held that an operator of a business establishment who provides free parking facilities to customers is not responsible for injuries to those who fall on ice or snow accumulated through natural means. Affirming the judgment of the trial court, the appellate court said it was only where the property owner created a more dangerous condition than that attributable to the natural accumulation of ice and snow that liability would be imposed.—*Hammond v. Allegritti*, 288 N.E.2d 197 (Ind.Ct. of App., Oct. 26, 1972).

### Test of Contributory Negligence

—In an action for malpractice, an Indiana appellate court ruled that the test of contributory negligence was not whether a patient had actual knowledge of a danger but whether he should reasonably have known of it or anticipated it.

The patient entered a hospital for confirmation of a tentative diagnosis of multiple sclerosis. On the day of his alleged injury, a nurse visited

his room after first determining that he had been given a sedative for a lumbar puncture earlier that morning. She later said he seemed alert when he awoke and talked to her. She assisted him to the bathroom and then proceeded to make the bed.

While the patient was in the bathroom, the nurse called to him several times to ask if he was ready to go back to bed. The last time, he asked her to come in. She found him sitting on the toilet, with hot water running over his back and shoulders from a pipe that was originally installed so that it could be pulled down over the toilet to wash out bedpans. The faucet that operated the apparatus was located on the wall to the patient's right.

The nurse turned off the hot water and went to get help to assist the patient back into bed. She later said she saw reddened and blistered areas over the patient's back and thighs.

The patient brought action against the hospital and two physicians for alleged negligence. The trial court granted a motion for judgment on the evidence as to one physician and a negative verdict as to the hospital and the other phy-

sician. The patient filed a motion to correct errors. The trial court granted a new trial as to the hospital but denied the patient's motion to correct errors as to the physicians. The hospital appealed.

In its ruling, the trial court found that there was no evidence that the patient had prior knowledge of the presence of the bedpan flusher installation or of the risk of being scalded. The court found that the jury's verdict was not supported by any of the evidence. The ruling indicated that the court thought that the hospital was negligent and that the patient was not guilty of contributory negligence.

The appellate court found that contributory negligence did not depend on the patient having actual knowledge of the danger but that it was sufficient to show that he reasonably should have known of the danger and could have avoided it by use of ordinary care. Reversing the judgment as to the hospital, the appellate court said that the trial court's reason for granting the patient a new trial was incorrect.—*Memorial Hospital of South Bend, Inc. v. Scott*, 290 N.E.2d 80 (Ind. Ct. of App., Dec. 12, 1972).

Most Americans apparently do not consider health care much of a problem. A Gallup Poll conducted recently asked the public to name the nation's two most important problems. Sixteen problems were identified (the cost of living led the list), but health care was not among them. At about the same time, a poll commissioned by Blue Shield of Massachusetts shows 56% of the public favors a federally sponsored national health insurance program, based on need and administered by private insurance firms, over a proposal similar to the Kennedy-Griffiths-Labor plan. Only 34% favor the latter. None of those interviewed complained about the quality of medical care.

After expressing dissatisfaction with their closed-panel Kaiser Foundation health care plan, several Teamsters locals in the Los Angeles area adopted a private-physician, fee-for-service plan developed by the Los Angeles County Medical Association. It provides comprehensive medical care and hospitalization for 10,000 union members and their dependents. Plan members choose their own physicians and hospitals, who maintain their freedom to practice privately and bill for services in the usual way. Bills are submitted to the Los Angeles County Health Services Corp., a non-profit subsidiary of LACMA.





This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to The Journal on the first of each month preceding month of issue.

The Administration hopes to come up with a new national health insurance plan by late September. HEW Secretary Caspar Weinberger said consideration centers around two approaches:

— A combination of employer-mandated coverage plus federally financed catastrophic protection, or

— A national plan modeled after the Federal Employees Health Benefits Program.

The two options listed by Weinberger aren't mutually exclusive. How the Federal Employees Program (FEP) could be translated into a national plan was not explained. Government workers under FEP can choose among high and low indemnity or service plans of private insurers and the Blues, with the federal government paying a set share. Prepaid group practice is another choice. Presumably, a national plan would have the private employers financing the share paid by Uncle Sam for U.S. workers.

The first-mentioned plan sounds like the previous Administration proposal with the exception of a strong catastrophic plank plus universal coverage, not provided before.

Whatever scheme is picked, Weinberger said, it will include a partnership concept involving private insurance and public agencies that will (1) assure that all have access to basic comprehensive coverage regardless of lack of sufficient income; (2) make judicious use of co-insurance and deductibles; and (3) contain features "to halt or at least sharply reduce medical cost inflation."

### **Calls for Health Insurance Premium Rollback**

Leonard Woodcock, president of the United Auto Workers, has called upon the Administration to roll back health insurance premiums under Phase IV of the Economic Stabilization Program. The labor leader who is chairman of the Committee for National Health Insurance (CNHI) said the commercial health insurance

industry "has reaped a huge windfall" under Phase II and Phase III regulations.

Woodcock said the six largest health insurance companies had "increased their net gain from group health operations to \$140.1 million last year from \$31.9 million in 1971 . . . a 350% increase."

He appeared at a Washington news conference with Luci Johnson Nugent, daughter of the late President Lyndon Johnson, and leading members of CNHI. Mrs. Nugent announced her support of the Kennedy-Griffiths health security bill backed by organized labor and the CNHI.

A spokesman for the Health Insurance Institute, representing the insurance industry, denied Woodcock's charges and said the industry experienced a profit of only 1.5 percent on premiums during 1972 based on an analysis of 20 companies.

"Because they were not windfall profits on a general, across-the-board basis, there would seem to be little need to roll back health insurance," the spokesman said.

### **Schmidt Named FDA Commissioner**

Alexander MacKay Schmidt, M.D., has been named Commissioner of the Food and Drug Administration.

Dr. Schmidt, 43, succeeds Charles C. Edwards, M.D., who is now Assistant Secretary for Health of HEW.

From 1970 until earlier this year, Dr. Schmidt was Dean and Professor of Medicine at the Abraham Lincoln School of Medicine, University of Illinois College of Medicine.

Dr. Schmidt previously served in HEW as chief of the continuing education and training branch, Regional Medical Program, from August 1967 until December 1968. From there he went to the University of Illinois College of Medicine as Executive Associate Dean and Associate Professor of Medicine, before being named Dean and Professor of Medicine.

Dr. Schmidt received the Bachelor of Science degree from Northwestern University in 1951 and his M.D.



degree from the University of Utah College of Medicine in 1955. From 1960 to 1967 he held various academic positions at the University of Utah College of Medicine.

### **New Brookings Report Published**

The prestigious Brookings Institution has come out with another provocative overview of U.S. Government policies that declares socialism in the European vein "has negligible support in the United States."

"... there appears to be little support for direct provision by the federal government of public services, especially such human services as education, health care, and law enforcement," the report says.

The Brookings report "Setting National Priorities—the 1974 Budget" last year proved a landmark "think piece" that helped set the tone for the Nixon Administration's domestic policy programs in 1974. That report urged "social experiments" by the government before embarking on major new national programs. Many believe the private foundation's report was a major factor in the Administration's decision to slash the scope of its Health Maintenance Organization (HMO) program to a strictly experimental project.

In the latest report's discussion of national health insurance (NHI), the concept of relating benefits to income is endorsed. This is a prime feature of the American Medical Association's Medigap proposal.

The Brookings report said:

"The type of proposal that seems best adapted to meeting all three criteria of equity, protection and efficiency is a national health insurance plan with income-related benefits. Under such a plan, both deductibles and co-insurance would be related to income so that people would be protected against expenses that were high relative to their income. To prevent undue financial burdens, a ceiling related to income could be placed on the out-of-pocket expenses a family would have to pay. One advantage of such an approach is that a single plan would serve the dual purpose of protecting the poor against normal expenses and protecting higher income people against heavy expenses; hence no stigma would be attached to receiving benefits under the plan."

### **Keogh Plan Liberalized but Restrictions on Retirement Savings Added**

The Senate Finance Committee has voted a substantial liberalization of the Keogh plan for self-employed people, including physicians, but also added restrictions on retirement savings by professional corporations.

Committee Chairman Russell Long (D., La.) said the reason for the restrictions was the fact that in some

cases professional men who had incorporated and who had high income could set aside on a deferred taxation basis as much as \$32,500 yearly while the self-employed were limited to a maximum of \$2,500.

Under the new Keogh plan limits set by the Committee, which are expected to win Senate approval, physicians, lawyers and dentists and other self-employed are allowed a deductible contribution to a retirement plan of up to 15% of earned income with a maximum of \$7,500 annually. There would be a \$100,000 limit on earned income that can be taken into account. (Present law limits retirement set-aside subject to tax deduction to 10% of earned income but not more than \$2,500).

According to the Committee, the \$100,000 limit means that "higher income self-employed, desiring to achieve the \$7,500 maximum contribution for themselves, will find it necessary to contribute on behalf of their employees at a 7.5% or greater rate."

The same self-employed plan limitations were imposed on retirement contributions on behalf of certain owner-managers of corporations.

An increasing number of physicians in recent years have formed professional corporations in order, among other reasons, to be able to invest more in retirement savings plans with tax deferrals than possible under the self-employed Keogh plan.

The new plan, believed to have the endorsement of the Administration, stands a good chance of Congressional approval.

### **AMA Supports Home Care Reimbursement Programs**

Congress has been asked to approve practical, realistic programs for reimbursing effective home health care agencies and programs.

The American Medical Association told the Senate Aging Subcommittee the range of home services covered by government programs needs reexamination.

"Physicians . . . who want the best possible care for their patients must be allowed to order and to provide preventive, supportive, and rehabilitative services at home as they presently do at other sites," testified Charles Weller, M.D., a member of the AMA's committee on community health care.

Dr. Weller noted that home care agencies have been protesting the Social Security Administration's policies on the home health provisions of Medicare, inasmuch as less than 1% of Medicare dollars go for this type of health care.

As evidence of the AMA's strong support of the concept, Dr. Weller pointed to the important home health services component in the AMA's Medigap national health proposal.

*Continued*



“Effective programs of home care services can reduce costly inpatient stays and achieve significant savings,” Dr. Weller said.

“In summary, the AMA actively supports the development and expansion of sound home care programs. We will continue to urge that they be covered under

both private and public programs. We believe they can aid selected patients, reduce costs, reduce institutionalization, and provide valuable assistance to physicians whose patients participate in them. More education is needed about the benefits of home care programs, and physicians will continue their efforts in this field.”

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**DESCRIPTION:** Methyltestosterone is 17 $\beta$ -Hydroxy-17-Methylandroster-4-en-3-one.

**ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone.

**INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

**PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

**CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

**WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued.

**ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

**DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.


INDICATION	Average Daily Dosage Tablets
In the male:	
Eunuchoidism and eunuchism	10 to 40 mg.
Male climacteric symptoms and impotence due to androgen deficiency	10 to 40 mg.
Postpubertal cryptorchidism	30 mg.

**HOW SUPPLIED:** 5, 10, 25 mg. In bottles of 60, 250.

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## Further Information With Regard to Indiana's New Medical Registration Law

We are reprinting below an article which appeared in the August issue of *The Journal*, in an effort to clear up the confusion it apparently has caused. The main purpose of the legislation was to raise the fee from \$5 to \$10 annually and to raise the penalty from \$10 to \$50.

Even though the law says "annually, on or before August 31st of each year," the Board of Medical Registration and Examination is authorized under another law (IC 1971, 25-1-2)

to collect the registration fees on a biennial basis. Therefore, those physicians who paid a two-year registration fee in 1972 are covered until 1974, at which time they will be notified by the board to remit \$20 for the '74 to '76 period.

This law does, however, apply to physicians who are registering for the first time this summer. These physicians have been notified by the board; so, **unless you have received a notice, don't worry, your license is still valid.**

---

The Board of Medical Registration and Examination of Indiana takes this opportunity to inform each person who holds a valid unrevoked certificate for a license to practice the healing arts in any form or manner granted by the Board of Medical Registration and Examination of Indiana that during the 1973 Legislature House Enrolled Act number 1305 pertaining to registration fees was enacted into law. The following is a verbatim copy:

### HOUSE ENROLLED ACT NO. 1305

AN ACT to amend IC 1971, 25-22-10-1 concerning professional licenses of the Board of Medical Registration and Examination as it relates to the annual reinstatement of fees.

*Be it enacted by the General Assembly of the State of Indiana:*

SECTION 1. IC 1971, 25-22-10-1 is amended to read as follows: Sec. 1. Every person who now holds, or may hereafter hold, a valid and unrevoked certificate for a license to practice the healing art in any form or manner, granted by either the state Board of Medical Registration and Examination

or by the Board of Medical Registration and Examination of Indiana, shall be required to register with the Board of Medical Registration and Examination of Indiana, in the form and manner determined by said board. Such registration shall be made annually, on or before August 31st of each year. Each applicant for registration shall submit with his application the sum of ten (\$10.00) dollars as the annual registration fee if he resides within the boundaries of the state of Indiana. All applicants residing outside the boundaries of the state of Indiana shall submit the sum of ten (\$10.00) dollars as the annual registration fee; provided, that no registration or fee for registration shall be required of any holder of a certificate on or before the month of July of the year following the year within which such certificate was issued. Failure of any such certificate holder to register and comply with the provisions of this chapter shall operate automatically to cancel his certificate, and any license issued thereunder and the continued practice after the cancellation of the certificate and license issued thereunder shall be considered as practicing without license. A certificate cancelled for failure to register may be reinstated by said board upon submission of the applicant's last registration certificate together with the current and delinquent fees and a penalty fee in the sum of fifty (\$50.00) dollars.

SECTION 2. Whereas an emergency exists for the immediate taking effect of this act, it shall be in full force and effect upon its passage.





## TAX TIPS

by LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

Many of you are employing part-time domestic help for one purpose or another, e.g., as household help or as yard help. Unfortunately, there are certain federal tax obligations which accompany such employment, and the I.R.S. is constantly surprising homeowners by requiring them to meet the homeowners' tax obligations in this respect.

Therefore, you may be interested to read the following seven points in order to decide what your obligations are.

1. The term *domestic* generally includes employees who are maids, cooks, babysitters, handymen, gardeners and housekeepers. The term does not include independent contractors.
2. If you pay gross wages of \$50 or more (of cash or the equivalent) in a calendar quarter to a domestic, then you must withhold F.I.C.A. tax (from such wages) in the amount of 5.85% of gross wages. In addition, you must match that amount from your own funds. Thus, you must pay F.I.C.A. taxes in a total amount of 11.7%.

3. Further, on or before the end of the month which follows the close of each calendar quarter for which any such tax is due, you must file federal Form 942 with the Internal Revenue Service Center, Memphis, Tenn., for *each* domestic.

4. Also, after the close of a calendar year in which any such tax is due, and on or before January 31 of the next year, you must give the domestic federal form W-2, and file a copy of the Form W-2 along with your final Form 942.

5. If the domestic retires, applies for F.I.C.A. benefits and is denied the benefits, because you did not make the contributions, you might be:

a. Sued by him directly, and/or

b. Required by the I.R.S. to pay all the back taxes (including the domestic's portion) plus 6% interest plus penalties of up to 25% of the unpaid tax.

6. It is not necessary to withhold either income or unemployment taxes.

7. For further details, see Rev. Rul. 71-389, 1971-2 CB 341.

The most offensive part of this tax obligation and procedure is that only the informed or extremely conscientious persons meet their obligation in this regard. Frequently, a domestic will refuse to work for any employer who wants to withhold F.I.C.A. taxes. And, if the employer is forced to pay the entire amount himself, the tax burden is quite sig-

nificant for an entire year. Thus, it seems to me that either the I.R.S. should strictly enforce the tax laws involved, or that the laws should allow employers and domestics to agree upon the employer's responsibilities. That is, the employers and domestics could agree: (1) to have the taxes withheld; (2) to have the employer pay all the taxes; or, (3) to eliminate the tax obligation entirely.

If you agree with any of these points, why don't you take the time to urge your Congressmen or Senators to have your view implemented?

\* \* \*

Many of you should begin taking advantage of the tax benefits which are offered by the federal Work Incentive Program (WIN). If you employ persons under the program, you can not only take an income tax deduction for the wages which you pay, but in addition, you can take a credit against your federal income tax liability in the amount of 20% of the cash wages which you pay during the first 12 months in which you employ persons under the program. While there is a maximum credit of \$25,000 which you may claim for any one year, there are carryback and carryover forward provisions for unused credits. Fortunately, the credit is available to individuals, trusts, estates and corporations. Therefore, if you are interested in this extraordinary tax savings, call the I.R.S. at (317) 633-8571 in order to obtain federal Form 4874. Further, call the Indiana Employment Security Division at (317) 633-6877 in order for them to certify you and to send you qualified applicants. ◀





## EARLY CARE OF THE INJURED PATIENT

The Committee on Trauma, American College of Surgeons, Philadelphia, W. B. Saunders Co.; 1972; 441 pages.

An early version of some of this material was first published in 1931 as a soft cover, pocket manual entitled, "An Outline of the Treatment of Fractures." With the burgeoning of trauma cases and subsequent interest in traumatology in recent years, the book has evolved into this rather extensive compilation of related topics under hard cover. The American College of Surgeons circulates it as a public service.

Twenty-four chapters comprise the contents with a preface and index. Every aspect of early injury is covered. In general, each organ system has a separate chapter; there are chapters on basic physiology as it relates to trauma such as "Cardio-pulmonary Resuscitation" or "Shock"; finally, there are miscellaneous headings such as "Primary Assessment and Management of the Injured," "Bites," "Legal Aspects," and so on. The treatment of fractures seems to be more detailed than other topics and may be related to the history of this as a fracture manual. Some of this excess might have been winnowed by the editor so as to encourage the reader in obtaining suitable orthopedic consultation in the emergency situation.

Chapter 22 is an instructive account of "Pulmonary Insufficiency After Trauma." This has many etiological and therapeutic ramifications and is undoubtedly a distressing occurrence. There are many chapters of equal interest too numerous to define here.

The book can be scanned in some sections because of the judicious use of bold type italics. This format is not used throughout the entire volume, however.

A symposium where each subject has many authors tends naturally to be of uneven quality. Generally though, the overall organization, presentation, use of illustrations and rhetoric here is good. Old information tends to march steadily on with this system though, as when Streptomycin and Penicillin combination is recommended as a primary broad spectrum antibiotic.

The non-specialist treating injuries and younger medical personnel will find this book a very handy reference. It has a place in every emergency room in the country.

RODNEY A. MANNION, M.D.  
Michigan City

## THE HANDY MEDICAL ADVISER AND CONCISE MEDICAL ENCYCLOPEDIA

Morris Fishbein, M.D., Garden City, N.Y., Doubleday, 1973.

This is a new revised edition of Morris Fishbein's classic manuals of medical advice for the laity. Actually, the book combines *Good Housekeeping's* POCKET MEDICAL ENCYCLOPEDIA and THE HANDY HOME MEDICAL AD-

VISER. Its author is, of course, well known to all physicians. The book, which comprises some 399 pages, is chock-full of the soundest sort of medical information for the family. The avowed goal of the book is to "give the reader a better understanding of his own medical troubles and thereby make him a better patient for his doctor." Perusal of the book convinces this reviewer that it accomplishes its purpose eminently well.

Part one, "The Handy Home Medical Adviser," has some 34 provocative chapters with such interesting titles as "Understanding Symptoms," "Inheritance of Disease," "Aging and Breakdown of the Body," "Loss and Gain of Weight," "Infections and Immunity," "The Care of the Feet," "Your Vacation," and "First Aid and Common Complaints." The second part, beginning on page 259, is a concise and useful encyclopedia of the more important symptoms and diseases that strike humans.

In view of the welter of unsound medical books for the laity presenting everything from harmless nonsense to downright dangerous counsel, Dr. Fishbein's authoritative manual represents a fresh breeze from the mountains. It is strongly recommended for family use. The book is attractively bound in hard cover, with easy to read print. It is reasonably priced at \$5.95.

W. D. SNIVELY, JR., M.D.  
Evansville

## PATTERNS OF INTEGRATION FROM BIOCHEMICAL TO BEHAVIORAL PROCESSES

Proceedings of a Symposium held at N.Y. Academy of Sciences in May, 1971 and published August 1972. Sponsored by the Section on Psychology and edited by Geo. G. Haydu. Annals of the N.Y. Academy of Sciences, Vol. 193; 310 pages; 26 contributors.

We M.D.s have a rather snooty survival from a preceding era of drawing a line between the *Psychiatrists* (indubitable M.D.s) and *Psychologists* who are thus placed firmly as being beyond the pale. This present volume—all articles by *psychologists*—is recommended reading; it should go far in removing archaic notions from the minds of my colleagues—the older generation, especially.

Of course, the very title is unfortunate. It seems to promise far more than can be delivered presently. We are still in the very first halting steps on the long road leading to a level on which we'll be able to write actual chemical formulae for such still unknown processes as "long term" vs. "short term" memory. We are only dimly beginning to recognize such divisions of our brains as "reptilian," "paleo-mammalian" and "neo-mammalian" (this including the uniquely human "neo-cortex." The function of the retinal amacrine cell (it lacks axons) is barely recorded as a fact. And: how does fast axoplasmic transport in CNS neurons aid the processes of plasticity and memory consolidation?

It is intriguing to be told that REM (rapid eye movements) relates to the catechol amine and that LSD modifies this balance profoundly in ways still to be explained. Just how does "integration of reality and fantasy" transform itself into "meaning"? But why go on? For a very modest price this symposium presents a very interesting insight into things yet to be and but dimly foreseen! This well printed paperback makes enjoyable and instructive reading at not too difficult a level.

ARNOLD LIEBERMAN, M.D.  
New York

*Continued*



## ABSTRACTS, BOOKS

Continued

### REVIEW OF MEDICAL PHYSIOLOGY

W. F. Ganong, M.D., Los Altos, Calif., Lange Medical Publications, sixth edition, 1973.

*Review of Medical Physiology* presents a concise summary of human physiology for medical students and "others." Others might well include practicing physicians who desire a succinct review of this all-important subject and candidates for advanced degrees in allied health sciences. Clinical examples are employed throughout the book to illustrate physiologic facts. Following the introduction there is a section on "Physiology of Nerve & Muscle Cells," then "Functions of the Nervous System," "Endocrinology & Metabolism," "Gastrointestinal Function," "Circulation," "Respiration," and "Formation & Excretion of Urine." The useful appendix includes a short section on statistics and a splendid list of abbreviations and symbols commonly used in physiology. The book is generously illustrated with line drawings, diagrams, charts and occasional photographs. The writing is clear and appropriate for the target audience. End papers present useful material. The book is attractively bound in heavy plastic. It is enthusiastically recommended for its target audience.

W. D. SNIVELY, JR., M.D.  
Evansville

### CORRELATIVE NEUROANATOMY & FUNCTIONAL NEUROLOGY

J. G. Chusid, M.D., Los Altos, Calif., Lange Medical Publications, 15th edition, 1973.

*Correlative Neuroanatomy and Functional Neurology* is designed for the beginner in clinical neurology. During the past five years, it has become increasingly popular with students, house staff members and practicing physicians, both in this country and abroad. The author presents succinctly and clearly important structural and functional features of the nervous system in relation to problems met in clinical neurology. The first 60 pages are devoted to a well-illustrated review of the central nervous system. Next follows a section on the peripheral and autonomic nervous systems. The third, and by all odds longest, section comprises chapters 8-35 and presents the principles of neurodiagnosis. The writing is unusually lucid. The illustrations are well thought out and understandable. Numerous tabulations and charts supplement the wealth of line drawings and occasional photographs. The appendix gives a detailed description of the neurological examination. I can recommend this fine volume enthusiastically for students, residents, and physicians, particularly family physicians, internists, and pediatricians. The book is attractively bound in flexible plastic cover.

W. D. SNIVELY, JR., M.D.  
Evansville

### HEMATOLOGY

Edited by W. J. Williams, E. Beutler, A. J. Erslev, and R. Wayne, New York, Blakiston Division of McGraw-Hill Co., 1972; 1480 pages, with innumerable tables, diagrams and some truly magnificent plates. In four parts and a three part appendix detailing laboratory techniques. Each section written by various authorities (total almost a hundred); \$35.00.

In our age of ever-increasing fragmentation and specializa-

tion of the various fields of Medicine, I find myself astonished by the sheer mass of knowledge represented by this massive new tome: Keefer's "Medicine" (*JISMA*, Oct. 1972, p. 1109) covers hematology in some 80 pages. The 12th edition of the Merck Manual (*JISMA*, Nov. 1972, p. 1182) does the same job in same number of pages but one-half the size. Even the 6th edition of Harrison's "Medicine" covers the topic in extenso in less than a hundred pages! By the way, M. Wintrobe, whose 5th edition of "Clinical Hematology" is on my working shelf (*JISMA*, 1962, p. 1353), wrote most of the material in Harrison's. I wonder why he has not brought his fifth edition up to date?

The reader may well wonder why the lengthy opening paragraph? It is *NOT* the maudlin meanderings of a senescent senior citizen! While the authors in their preface do *not* spell this out, this colossal monograph is most certainly aimed at the Hematology buff who knows the basics but is desirous of finding the exotic extras. Otherwise, why spend over two pages just tabulating Erythrocyte Disorders? Why close each chapter not with a summary but with an immense, all-encompassing bibliography of just that narrow sub-sub-specialty?

This tremendous "Handbuch"—in the good, old Germanic meaning of the word—deserves the widest dissemination in the libraries of medical schools, top notch laboratories and other such niches. And: I still believe that good, crisp summations of each chapter would be of clarifying aid to *all* readers—no matter how great their expertise! Of course, the paper, binding and printing are of the expected superb quality. The whole thing is outstanding: away above the expected norm!

ARNOLD LIEBERMAN, M.D.  
New York

### AGONIST AND ANTAGONIST ACTIONS OF NARCOTIC ANALGESIC DRUGS

Edited by H. W. Kosterlitz, H. O. J. Collier & J. E. Villarreal. A British Pharmacological Society Symposium, Baltimore, University Park Press, 1973; \$19.50. 290 pages with numerous tables, diagrams and up-to-date references.

The title is intriguing and the contents even more so! However, do not allow the steric formulae of so many new and exotic compounds deceive you into believing that the assemblage of pharmacological luminaries *really* is beyond the first groping steps into the uncharted seas! Just *how* does the conscious register pain? Just *what* creates addiction? *Why* do certain empiric modifications in the chemical formulae nullify the craving and yet stop the pain?

The authors synthesize a morphine derivative yclept *ETORPHINE*. It is some 10,000x more potent antinociceptive than morphine! Then: why deny M.D.s authority to use this agent experimentally just because it is 10,000 times more so than morphine? The discussion on page 121 is really of the greatest significance to all: practicing M.D.s or pure research professors.

This monograph is printed on splendid paper; it has splendid binding, and I failed to see any typo errors. I do think that *every* medical library deserves to have this volume on its shelves so that the entire staff—residents and interns included—can have ready access to its pages. It would be well were we all to read—and re-read—its pages!

ARNOLD LIEBERMAN, M.D.  
New York



Abstracts from Various  
Literature, Prepared by AMA

# **SURGICAL SCRUB— PRACTICAL CONSIDERATION**

R. B. Kundsın (Peter Bent Brigham Hosp., Boston 02115) and C. W. Walter.

*Arch. Surg.* 107:75-77 (July) 1973

Two scrubs were tested and compared under simulated conditions of use. The iodine preparation produced a greater immediate reduction in bacterial count than the hexachlorophene (HCP) preparation; however, this advantage was lost after one hour. The bacterial count inside the gloves following the iodine preparation increased after one hour and was higher than the count one hour following the HCP preparation. Because gloves are worn during surgery for periods longer than one hour, the choice of a scrub should be made on the basis of a prolonged depressant effect on the microbial flora of the hand. It is more appropriate to select a long-acting germicidal detergent than a single shot germicidal detergent with dwindling residual effect.

# **HEXACHLOROPHENE CONCENTRATIONS IN BLOOD OF OPERATING ROOM PERSONNEL**

H. R. Butcher et al. (Washington Univ. School of Medicine, St. Louis 63110).

*Arch Surg* 107:70-74 (July) 1973

The concentration of hexachlorophene (HCP) in the blood of operating room personnel who regularly scrub with Septisol (0.07 ppm) or pHisoHex (0.22 ppm) was compared to HCP blood levels of randomly chosen patients being admitted to the hospital (0.03 ppm). The mean blood concentration of those scrubbing with pHisoHex was seven times that of the patients; the concentration of HCP among Septisol users was twice the admission patient baseline. In a controlled laboratory study, nonmedical personnel scrubbed three times a day with the same HCP products for a period of two months. The mean HCP blood levels obtained were congruent with those found in the in-service study. Operating room personnel who scrub with Septisol can expect to have significantly lower hemic concentrations of HCP than exist among individuals who scrub with pHisoHex.

# **SCREENING FOR HEMOGLOBINOPATHIES EMPLOYING BLOOD SPECIMENS ON FILTER PAPER**

M. D. Garrick et al. (Bell Facility, P.O. Box U, Station B, Buffalo, N.Y. 14207).

*New Eng. J. Med.* 288:1265-1268 (June 14) 1973

Blood spots on filter paper are routinely collected in many areas for PKU testing of newborns. Several methods have been developed for detecting sickle cell disease and other hemoglobinopathies using this type of specimen. Simple, inexpensive modifications of existing methods are employed, permitting one technician to screen as many as 500 specimens per day at a cost of \$0.03 per specimen. Such an approach minimizes the logistic problems involved in collecting specimens to screen hemoglobinopathies.

# **EARLY HOSPITAL DISCHARGE AFTER MYOCARDIAL INFARCTION**

A. M. HUTTER, Jr. et al. (Massachusetts General Hosp., Boston 02109)

*New Eng. J. Med.* 288:1141-1143 (May 31) 1973

A prospective randomized controlled study compared a two-week and three-week hospital stay in 138 patients with uncomplicated but definite myocardial infarction. Patients with severe ventricular arrhythmias, heart block, hypotension, persistence of coronary pain or congestive heart failure into the fifth day, or a prior myocardial infarction within the preceding six months were excluded. During the six-month follow-up period, there was no difference between the 69 two-week patients and 69 three-week patients in incidence of return to work, anxiety or depression, development of angina or congestive failure, aneurysm formation, acute coronary insufficiency, myocardial infarction, or death.

# **INTENSIVE CARE IN MANAGEMENT OF DIABETIC KETOACIDOSIS**

N. G. SOLER et al. (General Hosp., Birmingham, England)

*Lancet* 1:951-954 (May 5) 1973

An intensive care approach to the management of diabetic ketoacidosis has reduced mortality to 16 (6.2%) among 258 patients treated between 1968 and 1972. While nine deaths occurred in complicated cases, seven were due to uncontrolled ketoacidosis. Hypokalemia, aspiration of gastric contents, acute renal failure, and hypothermia were the causes of death in uncomplicated ketoacidosis. The outcome of treatment was worse in the severely acidotic patients and mortality was related to the initial blood glucose and blood urea levels.







This month our report to you comes from Mrs. Edsel S. Reed, First Vice President and Membership Chairman. Her job is to reach those wives who are not already members of the Woman's Auxiliary. Won't you take this page home to share with your wife?

*Pat Strysdell*

### The Big "M" Challenge: Membership 1973-1974

Membership is the keystone of our organization. Our strength is in direct proportion to our membership total. **Indiana** would have won an AMA membership this June if we had had 3 more members!! I challenge you to put membership in the winner's circle, both for the AMA and the Indiana Auxiliary. Let us work together in spreading the AMA slogan — JOIN US. WE CAN DO MUCH MORE TOGETHER.

Membership = Manpower—an absolute essential.

Membership = Money—the source of funds to finance activities.

Membership = Mobilization—for action by providing the linkage between knowledge and action through structures of national, state and county auxiliaries.

**WHO** ALL Physicians' wives in Indiana.

**WHAT** Membership **YOU** are eligible to be a member of the Woman's Auxiliary.

**WHERE** All Counties — organized or unorganized. Each County Auxiliary is challenged to provide warm and gracious fellowship, interesting and informative programs and challenging and worthwhile projects. If you live in a county that has no organized auxiliary, you may be a member-at-large; the total membership fee is just \$6.00. For this fee you will be a member of both state and national auxiliaries and will receive the state publication, "Hoosier Doctor's Wife," and the national publications, "M.D.s Wife" and "The Direct Line." These keep you up to date on the national and local scene. As a member-at-large you are welcome to attend conventions and to suggest ways to improve the Auxiliary.

**WHY** We must recruit, retain and retrieve members to fulfill our objectives as an Auxiliary; to assist and participate in any requested endeavors of the Indiana State Medical Association.

**WHEN** NOW!!! Please use this form to obtain your 73-74 membership. Let our membership begin with **YOU!!!** If you are a physician's wife in an unorganized county and have not been contacted for membership, **HERE'S YOUR CHANCE!**

Mrs. \_\_\_\_\_ First Name \_\_\_\_\_

Street Address \_\_\_\_\_ County \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Please make your check payable to Treasurer, Woman's Auxiliary to ISMA, and send to: Mrs. Edsel C. Reed (Allie), Chairman Membership Committee, 111 Pawnee Drive, Jeffersonville, Indiana 47130.



# Just what do you get for your AMA dues?

You get a package of personal and professional services and benefits you've probably never been fully aware of.

You get insurance programs at a cost considerably lower than those purchased on an individual basis. A \$250,000 Excess Major Medical Policy. Group Life. Disability Income Insurance. Professional Liability Insurance (in co-sponsorship with your state society.) Then there's the AMA Members Retirement Fund.

You get a comprehensive medical library to help you do your research. An editing service for your articles. Information and reports on

medical and health subjects from any AMA department.

You get publications to keep you abreast of medical and health developments. *JAMA*. *American Medical News*. And *Prism*, the new socioeconomic journal.

You get the Physician's Placement Service to help you find a place to practice or locate an associate. And if you're a resident winding up your training, there's a special workshop to help prepare you for setting up your practice.

All these are just a few of a broad spectrum of benefits and services you get for your dues. But even more important, you get a strong and effective national spokesman to represent you, your interests and your views.

**Join us.**

**We can do much more together.**

American Medical Association  
535 N. Dearborn St./Chicago, Ill. 60610





# Opinion & Dialogue

## "Prescription drugs – who should determine the maker?"

Dispenser of  
Medicine

Clifton J. Latiolais  
President  
American  
Pharmaceutical  
Association



Maker of  
Medicine

C. Joseph Stetler  
President  
Pharmaceutical  
Manufacturers  
Association



"Too many doctors are indifferent to the economic consequences of their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by former AMA Chief Executive F. J. L. Blasingame, M.D.

### Doctor, are you indifferent...?

In discussing an anticipated increase in Blue Shield rates, Dr. Blasingame's newsletter had this to say:

"In general, it can be said, MD's have given the impression they are not particularly concerned with the increase in cost of health care to their patients...

"True, an MD's training is primarily scientific, but in the real world of practice, all of his scientific decisions have a price tag, or an economic impact. The economics of health care beckon the practitioner's attention. Concern for economics of medicine

When the pharmacist recommends that a drug product other than the one ordered be dispensed, the prescriber invariably permits the change when he feels the best interests of the patient will be served.

### Shortcomings of Pro-Substitution Argument

The fact remains that it is necessary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, the unilateral decision of the pharmacist, made in the absence of clinical knowledge of the patient, could expose him to needless risks, and in addition, jeopardize the relationship between the professions of Pharmacy and Medicine. In my view, there is nothing in the pro-substitution argument that offsets these risks.

### The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowledge about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degree, puts him at a disadvantage. Most often, a practicing physician will need expert knowledge of no more than 25



should be an obligation of medical practice...

"Medical societies ought to conduct continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in the patients' interest, question the tactics of any insurance organization that raises health care costs by forcing policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed to their patients for support in the fight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

### Cost of Drugs

Insurance rates and hospital charges are only two factors in health

care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists are *concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

### Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining

high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

### APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

*(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)*

or 30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with the particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substituting pharmacist may avoid even a technical breach of contract by simply notifying the patient that he is making the substitution. I would judge that few courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

### Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could follow legalization of substitution. We have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests

the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

### Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

### Summary

In short, what the American Pharmaceutical Association advo-

cates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

*(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)*

Pharmaceutical  
Manufacturers Association  
1155 Fifteenth Street, N.W.  
Washington, D.C. 20005







## New Plan for Medical Examination, Certification, Licensure, Offered

John P. Hubbard, M.D., President and Director of the National Board of Medical Examiners, recently presented a plan recommended by the National Board to simplify and harmonize the various systems of medical examination, certification and licensure in this country. Dr. Hubbard stated:

"Basic changes envisioned by the Board include a single qualifying examination upon graduation from medical school which, together with the medical school's evaluation, would enable state boards to grant a permit to practice medicine under supervision during graduate education.

"A full license for independent practice could then be awarded by a state board following completion of graduate medical education and specialty board certification. For those who are not certified by a specialty board, alternate prerequisites for licensure would be determined by the state boards.

"Beyond completion of graduate education and entry into practice, periodic evaluation of professional competence leading to re-certification and perhaps relicensure will almost certainly be required throughout the professional career of the physician. The responsibility for re-certification will rest, the National Board believes, with agencies that grant specialty certification in the first instance, the specialty boards."

The plan, which is designed to conform licensure to the present and future realities of medical education and practice, will, in the opinion of the National Board, require several years for refinement and establishment. In the interim it is expected that the National Board will continue with its present commitments and responsibilities.



DR. JAMES J. KIRTLEY, Crawfordsville, presented the American Academy of Family Physicians Medallion to Senator Vance Hartke recently to honor him for his support of the Health Care Insurance Act, better known as "Medicredit." Dr. Kirtley's presentation was on behalf of the Indiana Academy of Family Physicians.

## Two New Educational Programs Announced by PMA Foundation

The Pharmaceutical Manufacturers Association Foundation has continued to emphasize support of education rather than specific research projects, according to the Foundation's Annual Report.

The Report's title, "1972: A Year of Expansion" notes the two new educational support programs activated this year, a move in line with the goal set in 1971 of directing 80% of future support towards educational programs and 20% for research.

Foundation President C. Joseph Stetler pointed out that "with the new programs of fellowships in clinical pharmacology and the faculty awards in basic pharmacology, the Foundation now offers a sequence of awards at the medical student, postdoctoral and faculty levels aimed at assisting those inclined towards careers in the biomedical field at crucial points in career development. The real measure of the success of these programs rests on the efforts of the Foundation's advisory committees in identifying candidates who project a high probability for productive careers", he added.

Research support continues to be available, Stetler emphasized, but primarily through the research starter grants program, offered for the first time in 1971. This program offers \$5,000 to beginning investigators in the fields of pharmacology, clinical pharmacology and drug toxicology. It has an annual budget of \$200,000, allowing for up to 20 new grants a year.

The Foundation was established in 1965 to promote the betterment of public health through education and medical research. In the early years, support was characterized by relatively large research project grants. During 1968, the expenditure of funds was about equally divided between research and educational support and, by the end of 1972, educational programs received nearly seven of every ten support dollars.

The Report notes that since the Foundation's beginning, it has awarded more than \$4 million in research and training grants. The total number of awards made since the Foundation's beginning is listed in parentheses.

- 19 awards to medical school students to familiarize them with the fundamentals of clinical pharmacology. (113)
- 3 salary support awards to medical school faculty members to extend their research and teaching capabilities. (27)
- 5 fellowship awards to promote unique interdisciplinary approaches to drug research. (21)
- no general research grants awarded this year, but a total of 26 have been made covering various projects in pediatric pharmacology, adverse reactions and drug metabolism.
- 23 research starter grants. (43)
- 2 specialized meetings. (27)

## Infant Death Analysis Published

"Infant Death: An Analysis by Maternal Risk and Health Care" is a report of perinatal mortality in New York City in 1968, an experience involving 140,000 births. The Institute of Medicine of the National Academy of Sciences sponsored the publication, copies of which may be obtained from Printing and Publishing Office, 2101 Constitution Ave., N.W., Washington, D.C. 20418, at a cost of \$6.00 paperbound and \$8.00 clothbound.



**Leukemia Booklet Available**

The Leukemia Society of America has produced a new booklet designed to serve as a study aid for advanced students, nurses and paramedical personnel. The title is "Leukemia—The Nature of the Disease." Copies may be obtained without cost from the Society at 211 E. 43rd St., New York City 10017.

**Vacation Trip to England  
Includes Tour of Hospitals**

When members of the Indiana University Medical Alumni Association made a trip to London in July they visited a number of hospitals, including King Edward VII Hospital, St. Bartholomew's Hospital and the Hammersmith Hospital. They were also entertained at a dinner by the Royal College of Physicians and Eli Lilly and Company.

Among those attending from Indianapolis were: Dr. and Mrs. Berj Antresian and family, Dr. and Mrs. Lester D. Bibler, Dr. and Mrs. Drexell A. Boyd, Dr. and Mrs. Richard Brickley, Dr. Eleanor Deal, Dr. and Mrs. William D. Gambill, Dr. and Mrs. Glenn Irwin, Dr. and Mrs. William A. Karsell, Dr. and Mrs. J. Theodore Luros, Dr. and Mrs. John E. Owen, Dr. and Mrs. Joseph F. Thompson, Dr. and Mrs. J. L. West, Dr. and Mrs. Harold Williams.

Others attending from Indiana and other states were: Dr. and Mrs. Harold Manifold, Dr. and Mrs. H. R. Schell, Dr. and Mrs. Richard Schilling, all of Bloomington; Dr. C. Jules, Columbia City; Dr. and Mrs. Nicholas Louis Polite, Hammond; Dr. and Mrs. Robert Brubeck and Dr. and Mrs. John Van Wienen, Martinsville; Dr. and Mrs. Charles E. Walters, Mishawaka; Dr. Fletcher W. McDowell, Muncie; Dr. and Mrs. Jack McKittrick, Washington; Dr. and Mrs. Donald D. Small, Toledo, Ohio, and Dr. and Mrs. Kamal Sheena and Dr. and Mrs. Stephen White, Houston, Texas.

**Right Not to Drink Emphasized**

The United States Jaycees have launched a drinking campaign. They have adopted a resolution calling for responsible drinking on the part of those who drink. They are also emphasizing the acceptance of the individual's right not to drink. The campaign will extend into 6700 Jaycee communities all over the country. The effort will be expended through standard service messages by way of all the media.

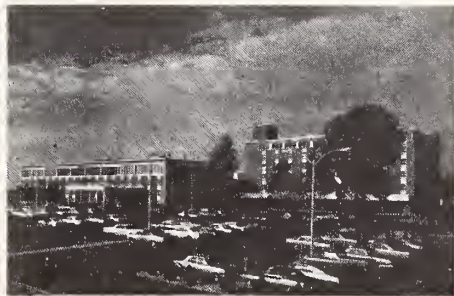
**\$100,000 Strauss Award Announced**

The National Multiple Sclerosis Society has announced the establishment of the Ralph I. Strauss Award, a prize of \$100,000 to be given to "that scientist or those scientists of any nationality whatsoever whose published research shall be judged to have resulted in the development of effective and specific methods of preventing or arresting multiple sclerosis." Mr. Strauss has stated that "The intent of this Award is to speed the conquest of multiple sclerosis through the enhancement in a realistic manner of the needed awareness of the vast social values inherent in the conduct of research in the biomedical sciences."

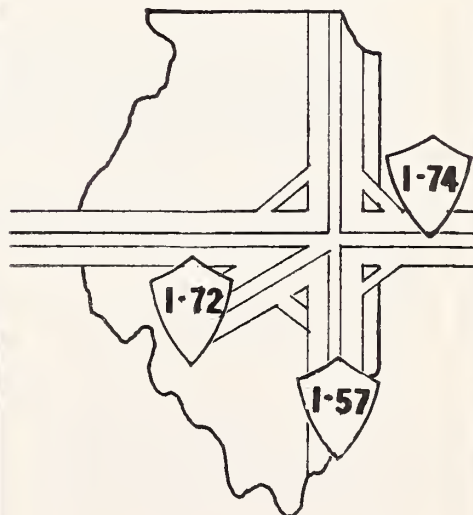
**TAP Meeting Set for French Lick**

The Joint Commission on Accreditation of Hospitals is sponsoring a series of meetings this fall to meet the growing  
*Continued*

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# News Notes

*Continued*

educational and informational needs of hospital trustees, administrators and physicians. Known as TAP institutes from the acronym for trustees, administrators and physicians, the meetings will be held in 15 locations. French Lick, Indiana, will be the site of TAP on September 28 to 30.

## Dr. McAtee Co-Authors Chapter Of "Advances in Neurology"

Dr. Ott B. McAtee, Madison, is the senior author of a chapter in "Advances in Neurology." Dr. McAtee with co-author Dr. Hazel Stevens reports a study of 95 cases of Huntington's Disease. Dr. Stevens also contributed a chapter in the same book on "Social Problems Related to Huntington's Chorea in Southern Indiana."

## Wyeth Offers New Film on Reproductive Endocrinology

Wyeth Laboratories is sponsoring a 25-minute color film on "Reproductive Endocrinology." A related monograph is given each physician in attendance. The film outlines means for preventing conception, including ovulation, diagnosing imbalance and treating deficiencies. Showings may be arranged thru Wyeth sales representatives or by writing Professional Service, Wyeth, P.O. Box 8299, Philadelphia, Pa. 19101.

---

## HANGER'S NETWORK OF PROSTHETIC CARE== ADDED SECURITY

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The logo for Hanger Prostheses features the word "Hanger" in a large, elegant, cursive script. Below it, the word "PROSTHESES" is written in a smaller, bold, sans-serif, all-caps font. The entire logo is enclosed within a thin, rectangular border.

1332 N. Illinois St., Indianapolis, Indiana 46202  
312 E. McMullan St., Cincinnati, Ohio 45219  
416 N. Main Street, Evansville, Indiana 47711  
3004 S. Wayne Ave., Fort Wayne, Ind. 46807

## Dr. Kelly Serves on S. S. "Hope"

Dr. Jack L. Kelley, general and vascular surgeon at the Arnett Clinic in Lafayette, has returned after spending two months as Chief of Surgery on the hospital ship S.S. "Hope." He spent time lecturing and operating, both on the ship and in the on-shore university hospital. The ship is docked this year about 15 degrees south of the equator at Maceio, Brazil.

## Dr. Byron Kilgore Appointed

Dr. Byron Kilgore has been appointed to the Mayor's Commission on the Status of Women in Fort Wayne. Commissioner Kilgore co-chairs the committee on Education and Religion. Statistical and attitudinal information will be obtained over the next year. Then material from the other committees on employment, legal services, community services, and government and politics will be combined. Recommendations will then be made toward equalizing the role and responsibility that women will assume in all phases of community life.

## Pediatric Nursing Program Offered

The Pediatric Nurse Associate Program, sponsored jointly by Indiana University School of Nursing, Division of Continuing Education and the Department of Pediatrics, Methodist Hospital of Indiana, Inc. is offered twice a year, in January and August. The program is funded by the National Institutes of Health and is designed to prepare registered nurses to be primary care providers to children in an ambulatory health care setting.

The course is 16 weeks in length and is full time in scope. There are specific blocks of time allowing for educational experience at the training center and application of knowledge and skill in the trainee's own ambulatory health care setting.

For further information, write Linda Offutt, R.N., M.S., Nursing Director, PNA Program, Methodist Hospital, 1604 N. Capitol Ave., Indianapolis 46202.

## Limited Vision Pamphlet Issued

"What Can We Do About Limited Vision?" is the title of Public Affairs Pamphlet #491. It is addressed to the problem of these people, usually children, who are not totally blind and may be rehabilitated to a considerable degree by special lenses and devices. A good reading assignment for members of the family of a patient with limited vision. The price is 35 cents. Write Public Affairs Committee, 381 Park Avenue, South, New York City 10016.

## Roche Resource Center Plans I.U. Medical School Series

The Roche Laboratories Resource Center will display its multiphasic informational exhibit at the Indiana University School of Medicine Student Union Building, First Floor Lounge, September 18 through 20, 1973.

The Center will be open for physician and student use from 9:00 a.m. to 5:00 p.m. daily, except Wednesday, when it will be open from 9:00 a.m. to 10:00 p.m.

Information provided by the Center is current and timely and employs the flexibility of modern communications equipment in which the physician can choose the subject he is interested in and view the latest advances in medical practice in a wide variety of subject areas.



# What's New?

Winthrop is introducing NegGram in pediatric form to treat urinary tract infections. NegGram Suspension has a raspberry flavor and should appeal to young patients and to adults who prefer liquid medication.

\* \* \*

Bristol Laboratories has received approval from FDA for Polycillin-PRB (ampicillin trihydrate with probenecid for oral suspension) recommended as a single oral dose treatment for uncomplicated gonorrhea. Polycillin-PRB is stable in the presence of gastric acid, is well absorbed from the GI tract and diffuses readily into most of the body tissues and fluids.

\* \* \*

Kendall announces Curity Maternity Care Kits are now available in 12 standard units. There are an infinite number of custom design kits, available in boxes, poly bags and diaper bags.

\* \* \*

The Health Law Center has published "HMO Sourcebook" a special edition of a continuing study of state laws affecting the prepayment of medical care, group practice and HMOs. The study is the reference source on HMOs for HEW and the 400-page special edition of this study, the "HMO Sourcebook," has been prepared for health professionals with HEW permission. The price is \$24.75. Write the Center at 11600 Nebel St., Rockville, Maryland 20852.

\* \* \*

Behavioral Publications has published a book "Behavior Modifications in Residential Treatment for Children." It is written by Frank J. Pizzat, Ph.D., of Gannon College to explain techniques which are useful in modifying behavior in a manner which will produce the desired normal attitudes and behavior after the subject is returned to the outside world. 98 pages, hardbound, \$7.95.

\* \* \*

Kendall announces that Kerlix® is now available in two new products. Ten Kerlix sponges are now packaged and sterilized in a plastic basin with a peel-open lid. Also the Kerlix packing sponge (4 1/2" x 25") with wide twist tape attached is available for packing large cavities.

\* \* \*

Crest-Foam announces a high-resilience, flame-retardant urethane foam trademarked "Safecrest Super-foam" which is recommended for mattress materials. It is tough, durable and long lasting, has excellent tensile strength. Its comfort qualities are considered to be as important as its flame-retardant qualities.

\* \* \*

American Hospital Supply announces a new, sterile Tomac Bantam Irrigation Set with Gemini Syringe which is designed for use in gravity and tube feedings. Also useful for injection and aspiration of irrigating solutions. The piston-type plunger is easily controlled and automatically aspirates.

\* \* \*

Metal Dynamics has a new and improved Automatic Wheel Chair Lift that has wider tracks to accommodate a greater variety of chair models and styles. Additional improvements include an Air-Glide feature that enables the patient, while still in his wheel chair and on the lift, to be moved to the examining equipment.

\* \* \*

"Alcohol: Our Biggest Drug Problem"—a new book by Joel Fort, M.D., just released by McGraw-Hill. It is a story of the economics and politics of the alcoholic beverage industry. It is the first book to deal with alcohol as a drug problem. The book sells for \$6.95 cloth and \$3.95 soft.

\* \* \*

Behavioral Publications has just released "Residential Treatment of Emotionally Disturbed Children." Edited by George H. Weber of the Center for Studies of Crime and Delinquency. Sells for \$14.95 hardbound.

\* \* \*

## DIRECTOR of MENTAL HEALTH

We are seeking a psychiatrist to direct the Milwaukee County Mental Health Center, a comprehensive community mental health center, organized into six catchment area programs including outreach stations located within the community. 1,000 acute and long-term psychiatric beds; an ultra modern day hospital; and, a soon to be completed 180 bed inpatient resident and day care treatment center for children and adolescents. The Center is a principal psychiatric teaching resource for the Medical College of Wisconsin and has training programs for interns, residents, nurses and other students.

Requires Wisconsin licensure or eligibility for same and at least 5 years comprehensive experience as a mental health director, educator, or administrator preferably in an accredited mental health program, university or hospital.

This is a timely opportunity since we can offer the person appointed to this position the chance to make several critical appointments to new subordinate positions. Excellent employee fringe benefit program and salary. Send vita to:

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Institutions & Departments  
8731 Watertown Plank Rd.  
Milwaukee, Wis. 53226**



## FUTURE MEETINGS, SEMINARS, COURSES

### Cancer Nursing Conference Set

The American Cancer Society will conduct its National Conference on Cancer Nursing at the Palmer House in Chicago on September 10 and 11. The sessions are open to professional nurses and professional nursing students only. There is no registration fee. Inquire from the ACS at 219 E. 42nd St., New York City, 10017.

### Announce National Conference On Cancer of Colon and Rectum

The American Cancer Society will conduct its second National Conference on Cancer of the Colon and Rectum at the Americana Hotel, Bal Harbour, Florida, on September 27 to 29. 15 elective hours are credited by the American Academy of Family Physicians. Inquire from the ACS at 219 E. 42nd St., New York City 10017.

### Rhinoplasty Workshop at Chicago

An advanced continuing education workshop in "Plastic Surgery of the Nose: Rhinoplasty and Reconstruction" will be held September 29 to October 3, under the direction of M. Eugene Tardy, Jr., M.D.

The course is jointly sponsored by the Department of Otolaryngology, University of Illinois Medical Center, the American Academy of Facial Plastic and Reconstructive Surgery, Inc., and Saint Joseph Hospital, Chicago.

For brochure and applications, please write M. Eugene Tardy, Jr., M.D., Department of Otolaryngology, Eye and Ear Infirmary, 1855 W. Taylor, Chicago, Ill. 60612.

### Riley Hospital to Host Symposium On Childhood Cancer Oct. 11, 12

The Comprehensive Childhood Cancer Symposium, sponsored by the Indiana University School of Medicine and the James Whitcomb Riley Hospital for Children, will be held in Indianapolis at Stouffer's Indianapolis Inn on October 11 and 12, 1973.

Topics include: Wilms' Tumor, Neuroblastoma, Rhabdomyosarcoma, Hepatic tumors, Teratomas, Retinoblastoma, Endocrine tumors, Testicular tumors, Bone tumors, Brain tumors, Histocytosis-X, the Leukemias, Lymphosarcoma, and Hodgkin's Disease.

Visiting faculty include: Drs. H. William Clatworthy, Jr., Robert Filler, Alvin Mauer, William Newton, Judson G. Randolph, Lucius Sinks, and William Tefft.

Registration fee is \$100, banquet and luncheons. For further information contact: Jay L. Grosfeld, M.D. or Robert L. Baehner, M.D., James Whitcomb Riley Hospital for Children, 1100 West Michigan St., Indianapolis 46202.

### Humane Association Sets Symposium

The Third National Symposium on "Protecting the Abused

and Neglected and Sexually Exploited Child" will meet at the Francis Marion Hotel in Charleston, S.C., on October 23. Write to Children's Division, The American Humane Association, P.O. Box 1266, Denver, Colorado 80201.

### Cleveland Clinic Announces 1973-74 PG Course Schedule

Postgraduate courses to be given at the Cleveland Clinic during the coming academic year have been announced and are as follows:

Dermatology for the Non-Dermatologist, Oct. 10 and 11

Current Status in Artificial Organs, Oct. 19 and 20

Pediatric Endocrinology, October 24 and 25

Gastroenterology, November 14 and 15

Advances in Ophthalmology, December 5 and 6

Gastrointestinal Surgery, January 16 and 17

Medical Progress for the Family Physician, January 30 and 31

Blood Banking, February 6 and 7

Current Concepts in Renal Disease and Hypertension, February 13 and 14

Diagnostic and Therapeutic Approach to Rheumatic Disease, February 20 and 21

Sports Medicine, February 27 and 28

Medical Progress and Its Relationship to Dentistry, March 6 and 7

Advances in Urology, March 13 and 14

Refresher Seminar in Pediatrics for Pediatricians and General Practitioner, March 20 and 21

Endocrine Pathology—Anatomic and Clinical, March 27 and 28

The Challenges of Reconstructive Orthopaedic Surgery, April 3 and 4

Infection Control, April 17 and 18

Symposium on Hydrocephalus Pathogenesis, Diagnosis and Treatment, May 1 and 2

Plastic Surgery for the General Surgeon, May 8 and 9

Advances in Antibiotics and Infectious Diseases, May 22 and 23

These programs in continuing medical education are accredited by the AMA and are acceptable for Category 1 credit toward the AMA Physician's Recognition Award.

For further information and detailed programs write to: Director of Education, The Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland, Ohio 44106.

### "Range of Normal" Program Scheduled

A Colloquium on "The Range of Normal in Human Behavior" will be held at the Shriners Burns Institute Auditorium at the University of Cincinnati Medical Center on October 19, 20 and 21. Address inquiries to Robert S. Daniels, M.D., University of Cincinnati, Cincinnati 45229. ◀



# COMMERCIAL ANNOUNCEMENTS

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**FAMILY PHYSICIAN** or Internist wanted to associate in busy practice with surgeon to take over load left by recently deceased physician. If salary desired, will negotiate or help him to start his own practice. Town of 25,000, very modern hospital facilities and office. Reply Box 383.

**EXCELLENT OFFICE SPACE** available, Professional Building, 6049 E. Washington St., Indianapolis. Five rooms, pharmacy in the building; available for immediate occupancy, adequate parking; near Interstates. Call 356-6087 or 882-0160.

**IMMEDIATE OPENING** for physician. Office and equipment for sale or lease. City of 10,000, area of 25,000. Wm. H. Cripe, M.D., 507 W. High, Portland, Ind. Phone 317-726-8450.

## OFFICE SUITE FOR RENT

Reception room, 3 treatment rooms, rest room. Steam heat and water furnished. \$150.00 per month. Paneled, drop ceilings, and Kentile floor. Location: 1356 West 21st Street, Indianapolis.  
Call: 638-0565 for appointment to see office.

**WANTED:** Family Physician or Internist to associate with ABFP physician in outstanding Wisconsin summer-winter resort area. Excellent office and hospital facilities in ideal living environment. Salary: \$30,000 first year, then full partnership. Contact Lewis L. Jacobson, M.D., Eagle River, Wis. 54521.

## NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be consid-

## FAMILY PRACTITIONERS

Excellent opportunity to thrive in a group setting. Premium financial reward. Partnership in one year. Great investment opportunities. Fringe benefits. Healthy active community with good schools located in northwest Indiana. Please contact: W. V. Hehemann, M.D., Department of Family Practice, The Hammond Clinic, 7905 Calumet Avenue, Munster, Ind. 46321.

**WANTED:** County Health Department Director, Northern Indiana. Pap. 126,500. Fast growing. Active generalized program. Paid vacation and holidays. Sick leave. M.D. or D.O. Reply Box 378, The Journal, ISMA, 3935 N. Meridian St., Indianapolis 46208.

G.P., Int. or Ped. Group practice possibilities. Will lease 14 rm., 2556 sq. ft. 1st fl. office. Sell equipment, Immediate occupancy. Area of 17,000, N.C. Ind. 1 1/2 hrs. from Chicago & Indianapolis. Hosp., New schools, Lake & other rec. fac. Retiring for health reasons. 2 generations practice est. 1902. D. K. Stinson, M.D., Rochester, IN 46975.

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Call Collect: Steve Stinson, Attorney: (219) 223-3900, Rochester, Indiana.

**FAMILY PRACTICE** opening January 1974 in two-man office. Cashmere, Wash., outstanding orchard community. Scenic area with unlimited recreation opportunities. Partner retiring. Initial salary and early partnership. Edgar A. Meyer, M.D. (Iowa '50) ABFP, 303 Cottage Ave., Cashmere, Wash. 98815 AC509/782-1541

**GOLDEN OPPORTUNITY** to own your own clinic building in Nora-Carmel area (north Indianapolis). 1400 sq. ft. office space; present dentist owner considering retirement. Would sell building and land for varied development. Would consider lease-back of space from new owner. Ample parking with exquisite landscaping. Tom Perkins' Gallery of Homes; call Susan Tintera: 846-7711 or 253-7391.

**EXCELLENT OPPORTUNITY** as a permanent associate in either family practice or internal medicine in a small, prosperous, local medical group. Also available are well paid "locum tenent" periods for those physicians who desire to work just a few weeks. Contact: Victor J. Vollrath, M.D. Phone: 317-253-1418.

**DIRECTOR OF UNIVERSITY STUDENT HEALTH SERVICE**—Indiana State University is seeking a staff physician and a Director of the University Student Health Service. Excellent facilities, good staff, 12,000 students, new laboratory, x-ray and pharmacy. Apply to John W. Truitt, Vice President for Student Affairs, Indiana State University, Terre Haute, Indiana 47809.

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Committee on Scientific Exhibits  
Indiana State Medical Association  
3935 N. Meridian Street  
Indianapolis 46208

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124th  
Annual Convention

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# Official Call to the House of Delegates

The next annual session of the Indiana State Medical Association will be held at the Indiana Convention-Exposition Center, Indianapolis, Indiana, October 8, 9, 10 and 11, 1973.

The House of Delegates will be constituted as follows: Marion County, twenty-two delegates; Lake County, nine delegates; Allen County, six delegates; St. Joseph and Vanderburgh county societies, each five delegates; Delaware-Blackford, Owen-Monroe and Tippecanoe county societies, each three delegates; Bartholomew-Brown, Daviess-Martin, Dearborn-Ohio, Elkhart, Fayette-Franklin, Fountain-Warren, Grant, Harrison-Crawford, Jackson-Jennings, Jefferson-Switzerland, LaPorte, Madison, Parke-Vermillion, Vigo and Wayne-Union county societies, each two delegates; the other fifty-six county societies, each one delegate; fourteen trustees and the ex-presidents, namely, Herman M. Baker, Karl R. Ruddell, M. A. Austin, M. C. Topping, Kenneth L. Olson, Earl W. Mericle, Guy A. Owsley, Maurice E. Glock, Donald E. Wood, Joseph M. Black, Kenneth O. Neumann, Eugene S. Rifner, Patrick J. V. Corcoran, Lowell H. Steen, Malcolm O. Scamahorn and Peter R. Petrich, and, ex-officio, the president, president-elect, the executive secretary, the treasurer and assistant treasurer of this Association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the President or person presiding shall cast the deciding vote. Two delegates are to be selected by the Indiana Chapter Student American Medical Association who shall be seated though without power to vote.

All delegates must present their credentials card certified by their county medical society before being seated as a delegate. No delegate will be seated without proper certification.

The House of Delegates will convene promptly at 9:00 a.m., EST, Monday, October 8, 1973, in the Ballroom of the Columbia Club. There will be a breakfast meeting at 7:00 a.m., Wednesday morning, October 10, in the Convention Center, and the final session of the House of Delegates will convene at 9:00 a.m., EST, Thursday, October 11, 1973, in the Indiana Convention-Exposition Center.

The order of business will be as follows:

1. Call to order by the president.  
Presenting of Colors by the Paul Coble Post of the American Legion.
2. Invocation by the Chaplain of the Paul Coble Post of the American Legion.
3. Roll call and seating of qualified delegates.
4. Announcements from the chair.
5. Tribute to members of the House or those who served the association in an official capacity and who have died since the 1972 session.
6. Reading of the minutes of previous meetings.
7. Introduction of guests.
8. President's address.
9. Appointment of Reference Committees and assignment of meeting rooms.
10. Unfinished business.
11. Address of the president-elect.
12. Report of president of the Woman's Auxiliary.
13. Report of Indiana Chapter Student AMA.
14. Report of president of Blue Shield.
15. Report of executive secretary.
16. Report of treasurer.
17. Report of chairman of the Board.

18. Reports of trustees.
19. Report of *The Journal* editor.
20. Report of AMA delegates.
21. Report of State Board of Medical Registration and Examination.
22. Reports of committees and commissions

## COMMITTEES

- (1) Executive
- (2) Grievance
- (3) Future Planning
- (4) Student Loan
- (5) Medical-Legal Review
- (6) Sports and Medicine
- (7) Medicine and Religion

## COMMISSIONS

- (1) Aging
  - (2) Constitution and Bylaws
  - (3) Convention Arrangements
  - (4) Emergency Medical Services
  - (5) Governmental Medical Services
  - (6) Interprofessional Relations
  - (7) Legislation
  - (8) Medical Economics and Insurance
  - (9) Medical Education and Licensure
  - (10) Public Health
  - (11) Public Information
  - (12) Special Activities
  - (13) Voluntary Health Agencies
  - (14) Specialty Medicine
23. New Business:
- (1) Matters referred by the Board of Trustees
  - (2) Matters referred by the Executive Committee
  - (3) Resolutions
  - (4) Selection of city for 1978 meeting  
1974—Indianapolis—October 5-10  
1975—Indianapolis—October 11-16  
1976—Indianapolis—October 9-14  
1977—Indianapolis—

The election of officers will be first order of business at the final meeting of the House of Delegates. In addition to the regular officers, the terms of the following AMA delegates and alternates expire December 31, 1973, and their successors must be elected at the session: delegates to the American Medical Association to succeed Jack E. Shields, Brownstown and Lowell H. Steen, Hammond; alternate delegates to succeed Patrick J. V. Corcoran, Evansville and Thomas C. Tyrrell, Hammond.

Delegates from the Third, Sixth, Ninth and Twelfth Districts are reminded that the terms of their trustees will expire October 11, 1973, and new trustees should be elected to succeed the following:

Third—Eli Goodman, Charlestown  
Sixth—Paul M. Inlow, Shelbyville  
Ninth—William M. Sholty, Lafayette  
Twelfth—William R. Clark, Sr., Fort Wayne

Some of these elections may already have been held, but they should be reported to the House of Delegates at this session for confirmation.

JAMES A. WAGGENER, Executive Secretary.



# HOUSE OF DELEGATES

Indiana State Medical Association  
Indianapolis—October 8, 9, 10 and 11, 1973

County and Delegates	Alternates	County and Delegates	Alternates
<b>ADAMS (1)</b> Norman E. Beaver, Berne		<b>DELAWARE-BLACKFORD (3)</b> Warren L. Bergwall, Muncie Paul Burns, Montpelier Ross Egger, Daleville	Larry Cole, Yorktown S. T. Sulit, Hartford City Richard L. Reedy, Muncie
<b>ALLEN (6)</b> William R. Cast, Fort Wayne Fred W. Dahling, New Haven John S. Farquhar, Fort Wayne Thomas A. Felger, Fort Wayne Michael J. Mastrangelo, Fort Wayne Marvin E. Priddy, Fort Wayne	William C. Ashman, Fort Wayne  Charles S. Giffin, Fort Wayne Thomas L. Herendeen, Fort Wayne John M. Hoog, Fort Wayne Harry D. Tunnell, Fort Wayne	<b>DUBOIS (1)</b> Bernard Kemker, Jasper	Daniel C. Drew, Jasper
<b>BARTHOLOMEW-BROWN (2)</b> C. David Ryan, Columbus Robert M. Seibel, Nashville		<b>ELKHART (2)</b> Patrick Campbell, Elkhart Frederick W. Bigler, Goshen	James R. Miller, Wakarusa Virgil R. Graber, Elkhart
<b>BENTON (1)</b> Donald L. McKinney, Otterbein		<b>FAYETTE-FRANKLIN (2)</b> William F. Kerrigan, Connersville Perry F. Seal, Brookville	Arlington M. Hudson, Connersville N. C. Guinigundo, Brookville
<b>BOONE (1)</b> Don W. Boyer, Lebanon		<b>FLOYD (1)</b> Everett E. Bickers, Floyd Knobs	Marshall Buchman, New Albany
<b>CARROLL (1)</b> T. Neal Petry, Delphi	Manuel Scheurich, Oxford	<b>FOUNTAIN-WARREN (2)</b> Max Hoffman, Covington A. S. Salvo, Williamsport	
<b>CASS (1)</b> Eugene T. Karnafel, Logansport	Marilyn L. Wagoner, Burlington	<b>FULTON (1)</b> P. D. Aluning, Rochester	J. D. Richardson, Rochester
<b>CLARK (1)</b> David H. Jones, Charlestown	Richard L. Glendening, Logansport	<b>GIBSON (1)</b> William R. Wells, Princeton	R. E. Weitzel, M.D., Princeton
<b>CLAY (1)</b> C. E. Moon, Brazil	William L. Voskuhl, Charlestown	<b>GRANT (2)</b> Robert M. Brown, Marion Herbert Khalouf, Marion	Shirley Khalouf, Marion Charles Kershner, Marion
<b>CLINTON (1)</b> Robert A. Hedgcock, Frankfort	E. L. Conrad, Brazil	<b>GREENE (1)</b> M. S. Mount, Bloomfield	Sam I. Rotman, Jasonville
<b>DAVIESS-MARTIN (2)</b> Robert H. Rang, Washington Emory B. Lett, Loogootee	Marshall H. Seat, Washington Robert E. Chattin, Loogootee	<b>HAMILTON (1)</b> R. Adrian Lanning, Noblesville	Joe R. Lloyd, Noblesville
<b>DEARBORN-OHIO (2)</b> Henry W. Conrad, Lawrenceburg Gordon S. Fessler, Rising Sun	Leslie M. Baker, Aurora	<b>HANCOCK (1)</b> James T. Anderson, Greenfield	James L. Garrison, Cumberland
<b>DECATUR (1)</b> Robert P. Acher, Greensburg	Ricardo C. Domingo, Greensburg	<b>HARRISON-CRAWFORD (2)</b> W. J. Brockman, Corydon R. Milton May, Laconia	Carl Dillman, Corydon
<b>DE KALB (1)</b> John C. Harvey, Auburn	E. E. Rogers, Auburn	<b>HENDRICKS (1)</b> Eric D. Clark, Plainfield	Joseph Kerlin, Danville



**County and Delegates****HENRY (1)**

Kenneth G. Hill,  
New Castle

**HOWARD (1)**

Jack W. Higgins,  
Kokomo

**HUNTINGTON (1)**

Richard Wagner,  
Huntington

**JACKSON-JENNINGS (2)**

John C. Linson,  
Seymour  
William Johnson,  
North Vernon

**JASPER (1)**

Ernest R. Beaver,  
Rensselaer

**JAY (1)**

James S. Fitzpatrick,  
Portland

**JEFFERSON-SWITZERLAND (2)**

Ott B. McAtee,  
Madison  
Diego C. Valenzuela,  
Vevay

**JOHNSON (1)**

Joseph W. Young,  
Greenwood

**KNOX (1)**

Virgil McMahan,  
Vincennes

**KOSCIUSKO (1)**

William C. Parke,  
Warsaw

**LA GRANGE (1)****LAKE (9)**

Henry S. Lebioda,  
Gary  
Walfred A. Nelson,  
Gary  
Thomas C. Tyrrell,  
Gary  
William G. Grosso,  
East Chicago  
David E. Ross,  
Gary  
Theodore R. Espy,  
Gary  
Charles D. Egnatz,  
Schererville  
Daniel T. Ramker,  
Hammond  
Leonard W. Neal,  
Munster

**LA PORTE (2)**

John Luce,  
Michigan City  
Fred Carter,  
LaPorte

**Alternates**

Wm. S. Robertson,  
Spiceland

Warren McClure,  
Kokomo

Paul E. Doermann,  
Huntington

William Blaisdell,  
Seymour  
Phillip White,  
North Vernon

Kenneth J. Ahler,  
Rensselaer

Howard C. Jackson,  
Madison

Hugh K. Andrews,  
Franklin

Malcolm S. Floyd,  
Vincennes

David W. Haines,  
Warsaw

J. J. Reed,  
Hobart  
Donald H. Rudser,  
Whiting  
Robert Goldstone,  
Gary  
Arthur Goldstone,  
Gary  
Lee Trachtenberg,  
Munster  
Nicholas L. Polite,  
Hammond  
Walter A. Repay,  
Munster  
Peter E. Gutierrez,  
Crown Point

P. J. Pilecki,  
Michigan City  
Barbara Backer,  
LaPorte

**County and Delegates****LAWRENCE (1)**

F. S. Dino,  
Bedford

**MADISON (2)**

John R. Wagoner,  
Anderson  
Lawrence E. Allen,  
Anderson

**MARION COUNTY (22)**

John W. Beeler,  
Indianapolis  
Albert M. Donato,  
Indianapolis  
A. Alan Fischer,  
Indianapolis  
Ted H. Gabrielson,  
Indianapolis  
Hubert N. Grimes,  
Indianapolis  
George Klutinoty,  
Carmel  
Karl M. Koons,  
Indianapolis  
E. Henry Lamkin,  
Indianapolis  
Loren H. Martin,  
Indianapolis  
B. T. Maxam,  
Indianapolis  
I. E. Michael,  
Indianapolis  
Robert N. McCallum,  
Indianapolis  
John G. Pantzer,  
Indianapolis  
Arvine G. Popplewell,  
Indianapolis  
Donald E. Stephens,  
Indianapolis  
D. Edmund Storey,  
Indianapolis  
Charles E. Test,  
Indianapolis  
Hugh K. Thatcher, Jr.,  
Indianapolis  
Morris E. Thomas,  
Indianapolis  
Hugh L. Williams,  
Indianapolis  
Malcolm L. Wrege,  
Indianapolis  
Fred L. Toumey,  
Indianapolis

**MARSHALL (1)**

Jose R. DeJesus,  
Plymouth

**MIAMI (1)**

Lloyd Hill,  
Peru

**MONTGOMERY (1)**

Richard R. Eggers,  
Crawfordsville

**MORGAN (1)**

Lowell Steele,  
Moresville

**NEWTON (1)**

Arthur Schoonveld,  
Brook

**Alternates**

James L. Mount,  
Bedford

Ted S. Doles,  
Middleton  
Robert W. McCurdy,  
Anderson

Berj Antreasian,  
Indianapolis  
James F. Balch,  
Indianapolis  
Richard A. Brickley,  
Indianapolis  
Rolla D. Burghard,  
Indianapolis  
Fred R. Brooks,  
Indianapolis  
James A. Crossin,  
Indianapolis  
Joseph M. Daly,  
Indianapolis  
Frank W. Fortuna,  
Beech Grove  
John D. Graham,  
Indianapolis  
Kenneth L. Gray,  
Indianapolis  
Gerald J. Kurlander,  
Indianapolis  
George T. Lukemeyer,  
Indianapolis  
Michael W. Manzie,  
Indianapolis  
John D. Moriarty,  
Indianapolis  
Dennis Nicholas,  
Indianapolis  
George F. Parker, Jr.,  
Indianapolis  
Stafford W. Pile,  
Indianapolis  
George H. Rawls,  
Indianapolis  
John N. Pittman,  
Indianapolis  
Joseph F. Thompson,  
Indianapolis  
Robert J. Yingling,  
Indianapolis  
Douglas H. White,  
Indianapolis

James S. Robertson,  
Plymouth

Maurice D. Sixby,  
Denver

James M. Kirtley,  
Crawfordsville

Robert J. Miller,  
Paragon

Marcus Guzman,  
Morocco



County and Delegates	Alternates	County and Delegates	Alternates
<b>NOBLE (1)</b> Carl F. Stallman, Kendallville	Ramesh S. Carpenter, Kendallville	<b>SPENCER (1)</b> John H. Barrow, Dale	Michael O. Monar, Rockport
<b>ORANGE (1)</b> Phillip T. Hodgin, Orleans	Charles X. McCalla, Paoli	<b>STARKE (1)</b> Guy B. Ingwell, Knox	Earl Leinbach, Hamlet
<b>OWEN-MONROE (3)</b> William R. Anderson, Bloomington Roger F. Robison, Bloomington Robert E. Rose, Spencer	Charles W. McClary, Bloomington Charles L. McKeen, Bloomington Rodger L. Buck, Spencer	<b>STEUBEN (1)</b> Donald G. Mason, Angola	Norman Richard, Angola
<b>PARKE-VERMILLION (2)</b> Franklin Swaim, Rockville Frederick J. Evans, Clinton	Milton Herzberg, Clinton	<b>SULLIVAN (1)</b> Glen McClure, Sullivan	Betty Dukes, Dugger
<b>PERRY (1)</b> Fred Smith, Jr., Tell City	Robert A. Ward, Tell City	<b>TIPPECANOE (3)</b> George M. Underwood, Lafayette George B. Davis, Lafayette Wallace R. Van Den Bosch Lafayette	R. E. Hannemann, Lafayette John A. Knote, Lafayette Richard P. Gripe, Lafayette
<b>PIKE (1)</b> Donald L. Hall, Petersburg		<b>TIPTON (1)</b> Meredith B. Gossard, Tipton	William A. Kurtz, Tipton
<b>PORTER (1)</b> Martin J. O'Neill, Valparaiso	Joel I. Hull, Chesterton	<b>VANDERBURGH (5)</b> George W. Willison, Evansville John D. Wilson Evansville Albert S. Ritz, Evansville Ray H. Burnikel, Evansville Bernard B. Rosenblatt, Evansville	Weston A. Heinrich, Evansville Forest F. Radcliff, Evansville John E. Heumann, Evansville Charles W. Hachmeister, Evansville Donald C. Buehner, Evansville
<b>POSEY (1)</b> L. John Vogel, Mt. Vernon	John R. Crist, Mt. Vernon	<b>VIGO (2)</b> Fred W. Dierdorf, Terre Haute Thomas J. Conway, Terre Haute	Paul Humphrey, Terre Haute James Cristee, Terre Haute
<b>PULASKI (1)</b> William R. Thompson, Winamac	Charles E. Heinsen, Winamac	<b>WABASH (1)</b>	
<b>PUTNAM (1)</b> Fred E. Haggerty, Greencastle	John Ellett, Coatesville	<b>WARRICK (1)</b> Carlos M. Ruiz, Boonville	Ernesto M. Camacho, Boonville
<b>RANDOLPH (1)</b> Lowell W. Painter, Winchester	B. D. Wagoner, Union City	<b>WASHINGTON (1)</b> C. Stanley Manship, Hardinsburg	
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<b>RUSH (1)</b> Frank H. Green, Rushville		<b>WELLS (1)</b> Truman E. Caylor, Bluffton	Louis F. Bradley, Bluffton
<b>ST. JOSEPH (5)</b> George M. Haley, South Bend Alfred C. Cox, South Bend Donald G. White South Bend Sam E. Bechtold, South Bend Charles O. Hamilton, South Bend	Wallace Tirman, South Bend Thomas A. Troeger, South Bend Gordon C. Cook, South Bend Charles Martin, South Bend Richard Schaphorst Mishawaka	<b>WHITE (1)</b> Gerald R. Bougher, Monticello	Max L. Fields, Monticello
<b>SCOTT (1)</b> Marvin L. McClain, Scottsburg	Manuel T. Dancel, Scottsburg	<b>WHITLEY (1)</b> Thomas Hamilton, Columbia City	
<b>SHELBY (1)</b> Wilson L. Dalton, Shelbyville	Thomas B. Tate, Shelbyville	<b>INDIANA STUDENT AMA (2)</b>	



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7th District—Joseph F. Ferrara, Franklin  
8th District—Richard G. Ingram, Montpelier

9th District—William M. Sholty, Lafayette  
10th District—Vincent J. Santare, Munster  
11th District—James A. Harshman, Kokomo  
12th District—William R. Clark, Fort Wayne  
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## AMA Delegates

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## Fifty-Year Club—1973

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Marian Hochhalter, Logansport

### FLOYD COUNTY

William H. Garner, Sr., New Albany

### JAY COUNTY

Forrest E. Keeling, Portland

### KNOX COUNTY

Ellsworth Beckes, Vincennes  
George H. Springstun, Oaktown

### LAKE COUNTY

Joseph Goldstone, Hallandale, Fla.  
(formerly Gary)

### MADISON COUNTY

Cecil S. Wright, Anderson

### MARION COUNTY

C. Bowen De Motte, Greenwood  
James W. Denny, Indianapolis  
LaVerne B. Hurt, Delray Beach, Fla.  
(formerly Indianapolis)  
Franklin B. Peck, Sr., Tucson, Ariz.  
(formerly Indianapolis)  
Byron Snider, Escondido, Calif.  
(formerly Indianapolis)

### MORGAN COUNTY

Leon Gray, Martinsville

### RUSH COUNTY

Clarence C. Atkins, Rushville

### TIPPECANOE COUNTY

Daniel H. McKinney, Omaha, Nebr.  
(formerly Lafayette)

### TIPTON COUNTY

Jean V. Carter, Tipton

### VANDEBURGH COUNTY

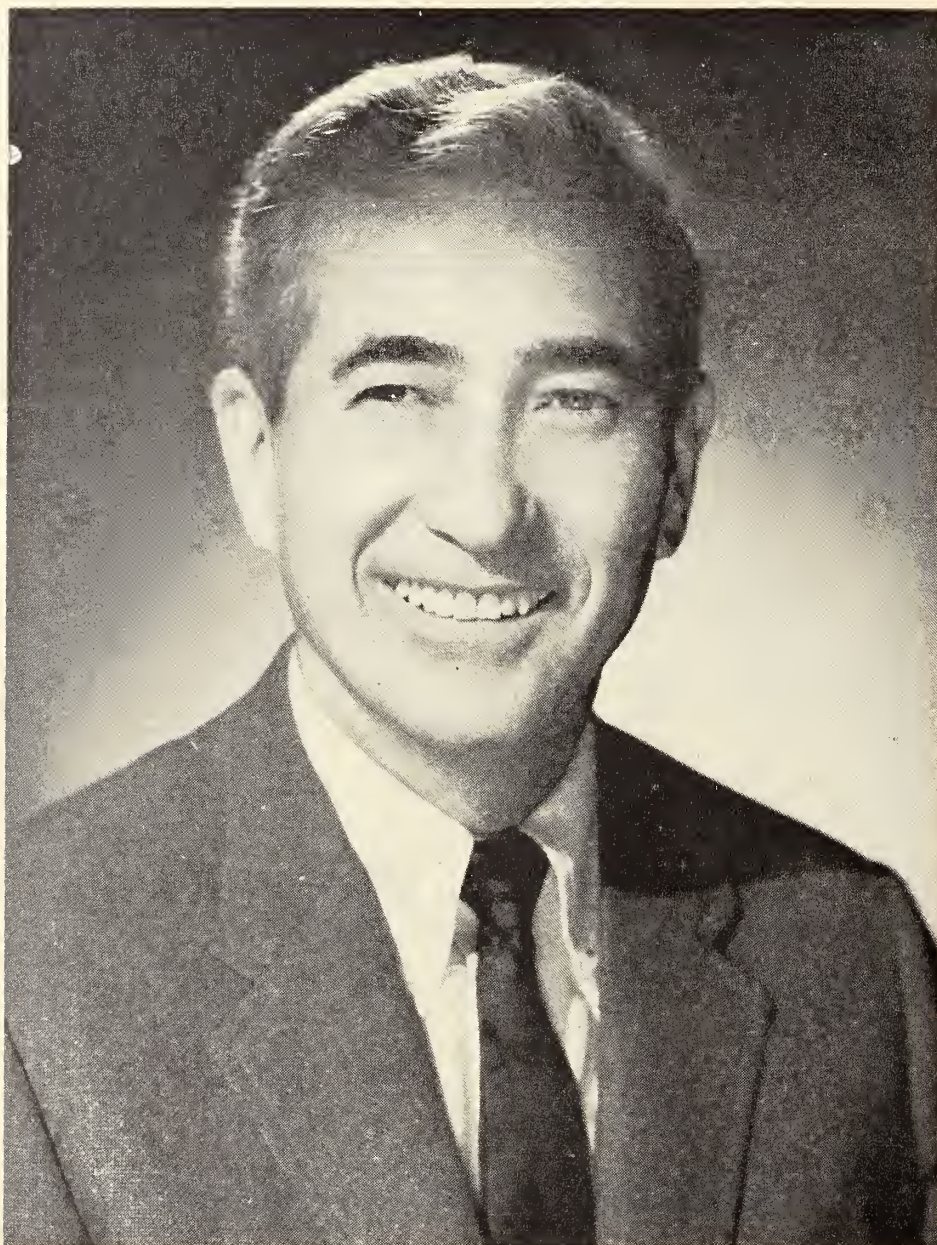
Alvin E. Newman, Fort Lauderdale, Fla. (formerly Evansville)

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## About Our Cover

We are indebted to the Indianapolis Power & Light Company for the cover photo of the Soldiers' and Sailors' Monument in downtown Indianapolis. Rather than one photo, however, this is a work of art which combines photos taken from several different angles.





JAMES H. GOSMAN, M.D.

President

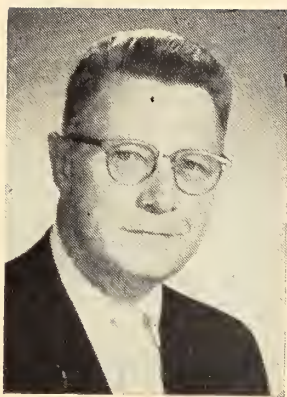
Indiana State Medical Association

1972 - 1973

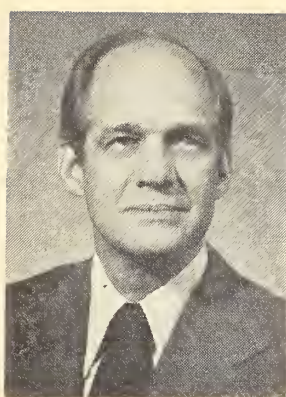




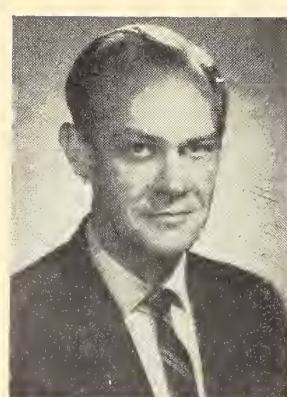
**JOE DUKES, M.D.**  
President-Elect  
Dugger



**HUGH K. THATCHER, JR., M.D.**  
Treasurer  
Indianapolis



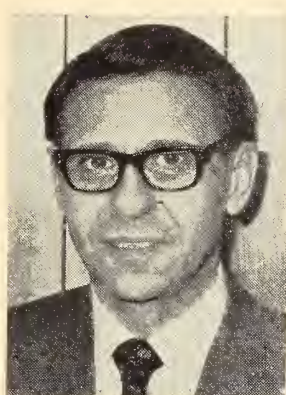
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Chairman of Board  
Evansville



**DONALD M. KERR, M.D.**  
Chairman  
Executive Committee  
Bedford



**MARVINE POPPLEWELL, M.D.**  
Asst. Treasurer  
Indianapolis



**VINCENT J. SANTARE, M.D.**  
Executive Committee  
Munster



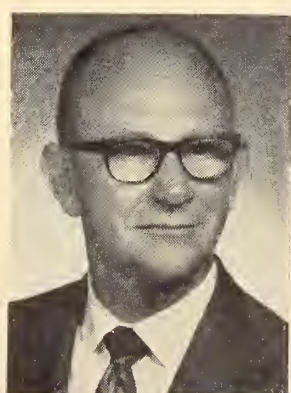
**PAT STOGSDILL**  
President Auxiliary  
Indianapolis



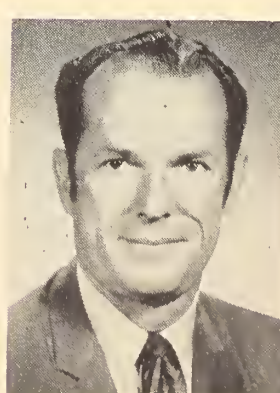
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Executive Secretary  
Indianapolis



**KENNETH W. BUSH**  
Administrative Assistant  
Indianapolis



**ROBERT J. AMICK**  
Field Secretary  
Scottsburg



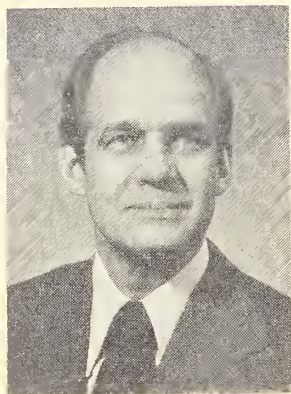
**HOWARD GRINDSTAFF**  
Field Secretary  
Indianapolis



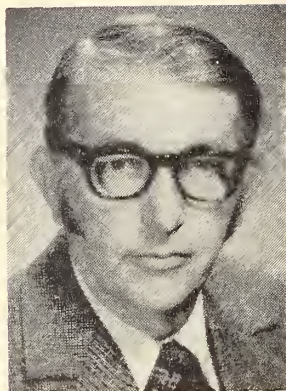
**MICHAEL McDERMOTT**  
Legislative Assistant  
Indianapolis



# Board of Trustees



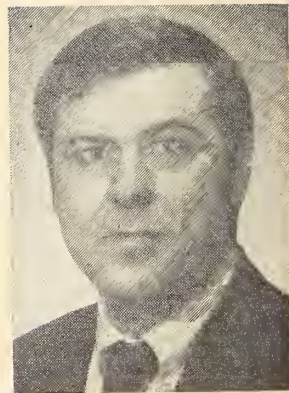
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M.D.  
Evansville



PAUL W. HOLTZMAN, M.D.  
Bloomington



ELI GOODMAN, M.D.  
Charlestown



HOWARD C. JACKSON,  
M.D.  
Madison



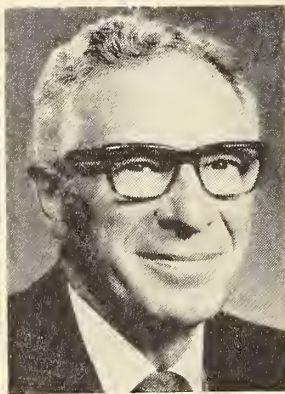
CLEON M. SCHAUWECKER,  
M.D.  
Greencastle



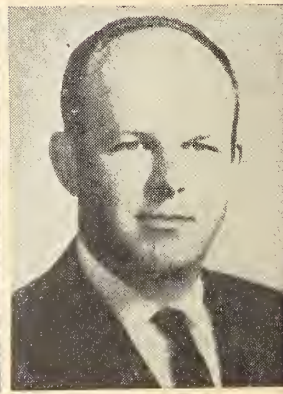
PAUL M. INLOW, M.D.  
Shelbyville



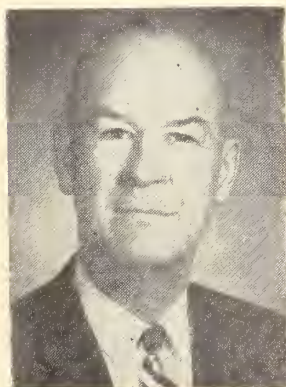
JOHN O. BUTLER, M.D.  
Indianapolis



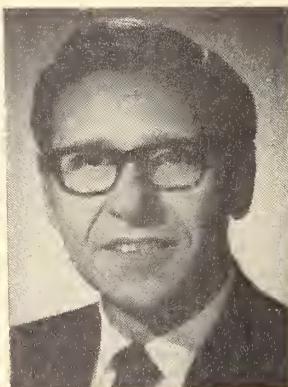
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Franklin



RICHARD INGRAM, M.D.  
Montpelier



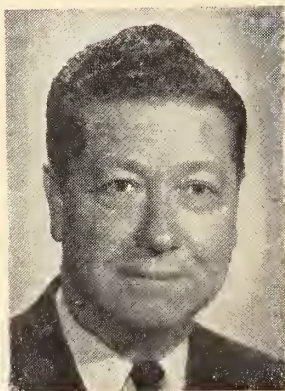
WILLIAM M. SHOLTY, M.D.  
Lafayette



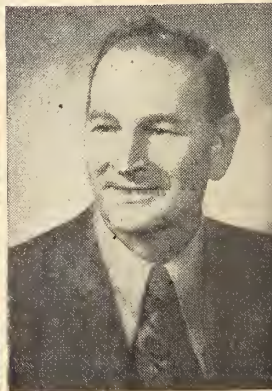
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Munster



JAMES A. HARSHMAN,  
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WILLIAM R. CLARK, M.D.  
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G. BEACH GATTMAN, M.D.  
Elkhart



# The Journal



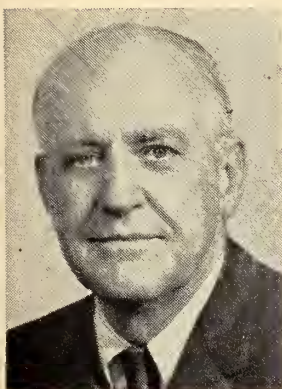
**FRANK B. RAMSEY, M.D.**  
Editor  
Indianapolis



**A. W. CAVINS, M.D.**  
Associate Editor  
Terre Haute



**L. G. MONTGOMERY, M.D.**  
Associate Editor  
Muncie



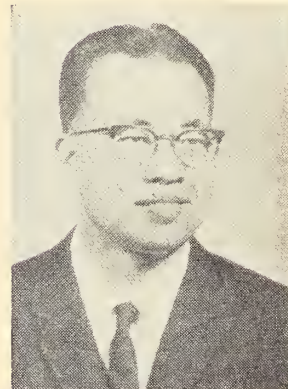
**SAMUEL R. MERCER, M.D.**  
Associate Editor  
Fort Wayne



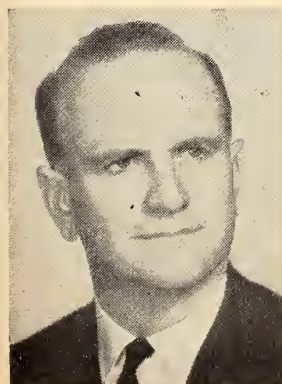
**IRWIN W. WILKENS, M.D.**  
Associate Editor  
Indianapolis



**ALVIN J. HALEY, M.D.**  
Editorial Board  
Fort Wayne



**WEI-PING LOH, M.D.**  
Editorial Board  
Gary



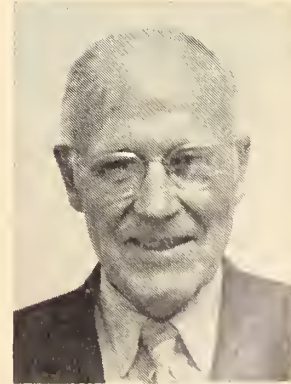
**W. D. SNIVELY, JR., M.D.**  
Editorial Board  
Evansville



**STEVEN C. BEERING, M.D.**  
Editorial Board  
Indianapolis



**ELTON HEATON, M.D.**  
Editorial Board  
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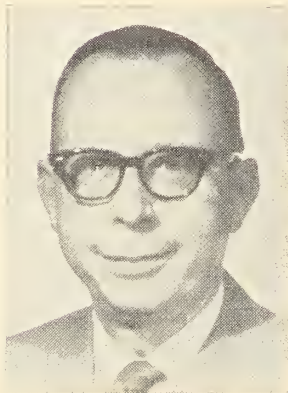


LOWELL HILLIS, M.D.  
Logansport

## Internal Medicine



ROBERT L. RUDESILL, M.D.  
Indianapolis

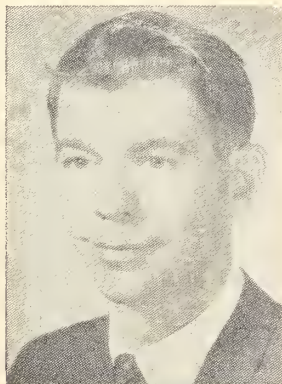


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Hammond



CHARLES W. MAGNUSON,  
M.D.  
South Bend

## Ophthalmology and Otolaryngology



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M.D.  
Fort Wayne



WALLACE K. DYER, M.D.  
Evansville

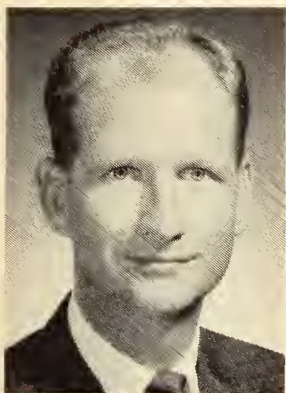


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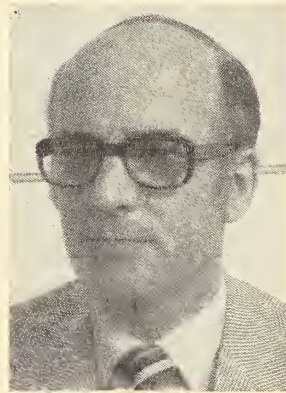
## General Practice



**JAMES T. ANDERSON, M.D.**  
Greenfield



**JAMES R. DAGGY, M.D.**  
Richmond

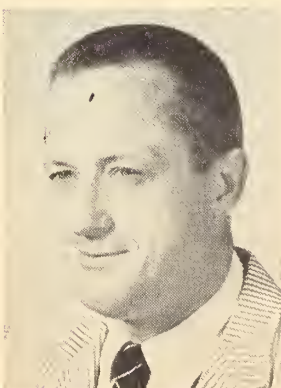


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Plainfield

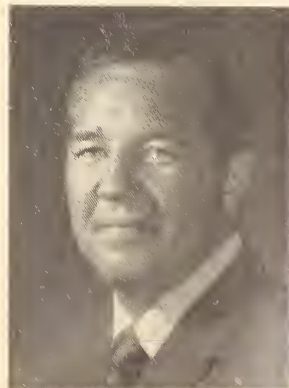
## Obstetrics and Gynecology



**JEROME F. DOSS, M.D.**  
Kokomo



**DAVID E. COPHER, M.D.**  
Indianapolis



**CHARLES R. THOMAS, M.D.**  
Indianapolis



Public Health and Preventive Medicine

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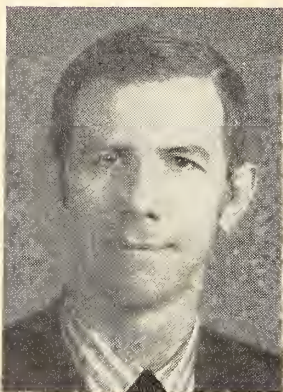


DAVID EDWARDS, M.D.  
Indianapolis

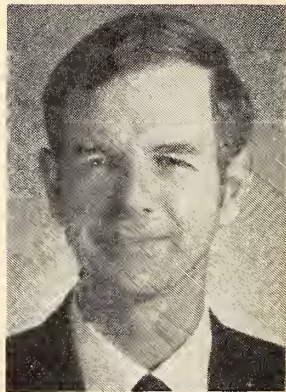
Radiology



JAMES G. LORMAN, M.D.  
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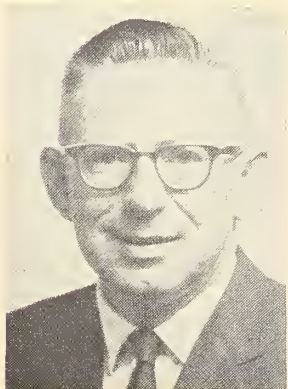


L. RAY STEWART, M.D.  
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Richmond

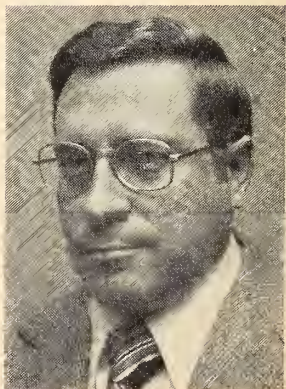
Nervous and Mental Diseases



WESLEY A. KISSEL, M.D.  
Indianapolis

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WALLACE R. VAN DEN  
BOSCH, M.D.  
Lafayette



RICHARD N. FRENCH, JR.,  
M.D.  
Indianapolis



## Pathology and Forensic Medicine

### CHAIRMEN



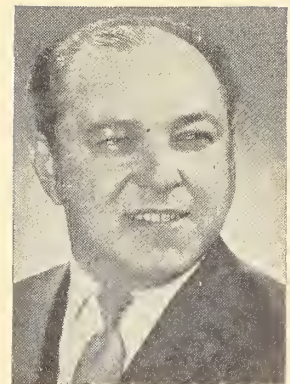
CLYDE G. CULBERTSON, M.D.  
Indianapolis

### VICE-CHAIRMEN



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Gary

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VICTOR MULLER, M.D.  
Indianapolis

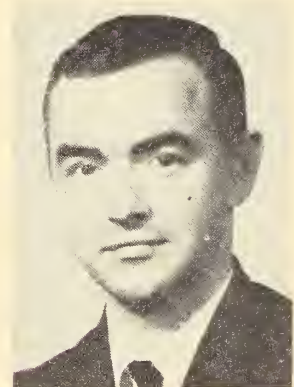
## Pediatrics



GEORGE F. PARKER, M.D.  
Indianapolis

NO  
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JOHN R. PONCHER, M.D.  
Valparaiso



ROBERT M. SWEENEY, M.D.  
South Bend

## Directors of Medical Education



LINDLEY H. WAGNER, M.D.  
Lafayette

NO  
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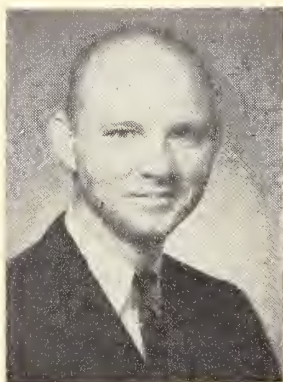
JOHN L. CULLISON, M.D.  
Muncie

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W. THOMAS SPAIN, M.D.  
Evansville



CHAIRMEN



JERE D. GUIN, M.D.  
Kokomo

VICE-CHAIRMEN



HOWARD R. GRAY, M.D.  
Indianapolis

SECRETARIES

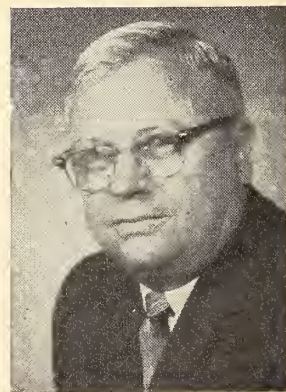


VICTOR G. HACKNEY, M.D.  
Indianapolis

College Health Physicians



JOHN MILLER, M.D.  
Bloomington



WAYNE C. PIPPINGER,  
M.D.  
Muncie

## Convention Arrangements Committees—1973

**COMMISSION ON CONVENTION ARRANGEMENTS:** Glen McClure, Sullivan, chairman; Claude J. Meyer, Jeffersonville, vice-chairman; Ray Burnikel, Evansville; Harold W. Richmond, Columbus; Paul Siebenmorgen, Terre Haute; James T. Anderson, Greenfield; Kenneth G. Kohlstaedt, Indianapolis; John R. Stanley, Muncie; Howard R. Marvel, Lafayette; Adolph P. Walker, Munster;

Bernard R. Hall, Logansport; Charles H. Aust, Fort Wayne; Herbert C. Ufkes, North Judson; Alvin H. Haley, Fort Wayne; S. O. Waife, Indianapolis; John L. Ferry, Hammond and Mrs. Richard B. Schnute, Indianapolis.

**SCIENTIFIC EXHIBITS:** Claude J. Meyer, Jeffersonville, chairman.

**WOMEN PHYSICIANS:** Glen McClure, Sullivan, chairman.

**GOLF TOURNAMENT:** Joseph E. Ball, Wayne H. Thompson and Mrs. Thomas W. Johnson, Indianapolis, co-chairmen.

**AUXILIARY and WOMENS ACTIVITIES:** Mrs. Richard B. Schnute, Indianapolis, general chairman.

**ART and HOBBY SHOW:** Mrs. Harry Siderys and Mrs. Harold G. Halbrook, Indianapolis, co-chairmen.



# Schedule of Events

124th Annual Convention  
Indiana Convention-Exposition Center  
100 S. Capitol Avenue  
Indianapolis, Indiana

*(All Events will be on Eastern Standard Time)  
(The scientific program for the 124th annual convention of the  
Indiana State Medical Association is acceptable for 14¾ Elec-  
tive and 4¼ Prescribed accredited hours by the American  
Academy of Family Physicians. The prescribed hours are for  
attendance at the Family Physicians Section meeting.)*

## Sunday, October 7, 1973

- 9:00 a.m. Executive Committee meeting,  
Columbia Club, Walnut Room  
12 Noon Board of Trustees luncheon meeting,  
Columbia Club, Parlors B and C  
8:00 p.m. Board of Trustees Annual Dinner, Third  
Floor, Columbia Club

## Monday, October 8, 1973

- 9:00 a.m. Meeting of House of Delegates, Ballroom,  
Columbia Club  
11:00 a.m. Golf Tournament, Hillcrest Country Club,  
6098 Fall Creek Rd.  
(Tournament for men and women)  
12 Noon Past Presidents' Luncheon,  
Columbia Club, Fairbanks Room  
2:00 p.m. Reference Committee meetings  
Reference Committee No. 1,  
Parlor C, Columbia Club  
Reference Committee No. 2,  
Parlor A, Columbia Club  
Reference Committee No. 3,  
Parlor B, Columbia Club  
Reference Committee No. 4,  
Ballroom Foyer, Columbia Club  
Reference Committee No. 5,  
Ballroom, Columbia Club  
(If necessary, Reference Committees will  
meet in the evening.)  
6:00 p.m. Women Physicians Dinner, LaTour Res-  
taurant, Indiana National Bank Build-  
ing  
Speakers: Phil Eskew, Secretary, Indiana  
High School Athletic Asso-  
ciation  
Patricia Roy, Director of Girls  
Athletics, IHSAA

## Tuesday, October 9, 1973

- 8:00 a.m. Board of Trustees Breakfast  
Room 226, Convention Center  
8:00 a.m. County Medical Society Executives  
Breakfast, Dining Room, Hilton Hotel  
8:30 a.m. Registration Begins  
9:00 a.m. Opening of technical and scientific ex-  
hibits  
9:00 a.m. PSRO HEARING (Professional Stand-  
ards Review), Room 210

## GENERAL MEETING

- 9:30 a.m. QUALITY OF LIFE PROGRAM  
(Presented by AMA)  
Room 211-212, Convention Center  
Call to order by James H. Gosman, President  
12 Noon Editorial Board, luncheon meeting,  
Room 225, Convention Center  
12 Noon IMPAC LUNCHEON  
Ballroom, Convention Center  
1:00 p.m. Meeting of Small County Delegates,  
Room 104, Convention Center  
2:00 p.m. IMPAC Workshop,  
Room 210, Convention Center  
2:00 p.m. Blue Shield Hearing, Room 224  
2:00 p.m. Organizational meeting of Interns and  
Residents (Interns and Residents are  
invited and expected to attend section  
meetings of their interest.) Room 105  
Time allowed to visit exhibits  
5:30 p.m. Social Hour (Cash Bar) Atkinson Hotel  
Ballroom  
6:30 p.m. Dinner - Theatre Party, Atkinson Hotel  
Ballroom  
The Tudor Troupers will present "Marri-  
age-Go-Round"

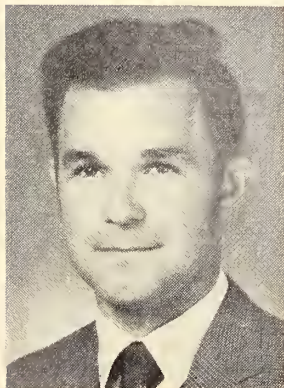
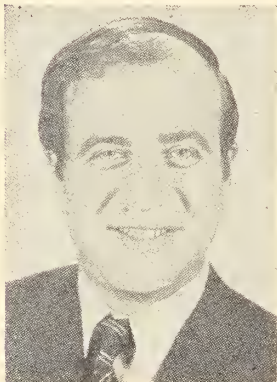


SPEAKERS



**CHARLES E. DRISCOLL, M.D.**  
Muncie  
An associate member of the American Academy of Family Practice, teaches in Ball Memorial Hospital Family Practice Program; M.D. degree from University of Iowa Medical School in 1971.

**RICHARD S. BAUM, M.D.**  
Indianapolis  
Director of Neonatal Pediatrics at Methodist Hospital, Indianapolis; member of Governor's Task Force on Maternal and Child Health and of the ISMA Ad Hoc Committee on Maternal and Child Care; Fellow, American Board of Pediatrics; diplomate, National Board of Medical Examiners; M.D. degree from Columbia University College of Physicians and Surgeons, 1959.



**RICHARD D. GRABER, M.D.**  
Indianapolis  
Chief Resident, Family Practice Program, Methodist Hospital, Indianapolis; won Mead Johnson Award for Postgraduate Medical Education in Family Practice in 1972; graduate of Indiana University School of Medicine in 1971.

**Wednesday, October 10, 1973**

- 7:00 a.m. Breakfast Meeting, House of Delegates, Room 210, Convention Center
- 8:30 a.m. Registration Continues
- 9:00 a.m. Opening of technical and scientific exhibits
- 10:30-11:00 Time allowed to visit exhibits
- 2:00 p.m. Business meeting of Phi Beta Pi Fraternity, Room 224, Convention Center

**Section and Specialty Meetings**

*(Programs are listed alphabetically)*

**Section on Cutaneous Medicine  
Room 104, Convention Center**

- 9:00 a.m. "IMMUNOTHERAPY," Edmund Klein, to M.D., Buffalo, N.Y.
- 12:00 Noon

**Section on Family Physicians  
Room 105, Convention Center**

- 9:00 a.m. "THE USE AND ABUSE OF DIGITALIS," R. Joe Noble, M.D., Indianapolis
- 10:00 a.m. "DISORDERS OF THE ANUS AND RECTUM," Charles E. Driscoll, M.D., Muncie  
Election of Section Officers for 1974
- 11:30 a.m. to Time allowed to visit exhibits
- 12 Noon
- 12 Noon Buffet Luncheon, Exhibit Hall  
Meeting Continuing
- 2:00 p.m. Special Session on "BASIC SKILLS IN NEWBORN CARE, I," Richard S. Baum, M.D., Indianapolis and Richard D. Graber, M.D., Indianapolis
- 2:45 p.m. to Break
- 3:00 p.m.
- 3:00 p.m. "BASIC SKILLS IN NEWBORN CARE, II," Richard S. Baum, M.D., Indianapolis and Richard D. Graber, M.D., Indianapolis
- 4:00 p.m. to Time allowed to visit exhibits
- 4:30 p.m.

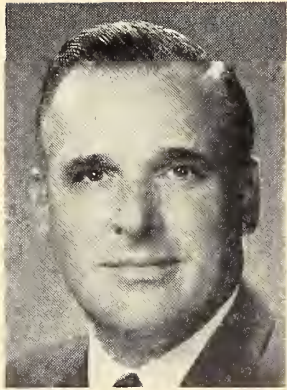


Wednesday Morning, Oct. 10, 1973

Joint Meeting of Section on Internal Medicine, Indiana  
Society of Internal Medicine, Indiana Chapter of The  
American College of Physicians  
Room 227, Convention Center

- 9:00 a.m. Introduction—Donald E. Wood, M.D.,  
F.A.C.P., Indianapolis
- 9:15 a.m. Scientific Program—Moderator, Walter J.  
Daly, M.D., F.A.C.P., Indianapolis
- 9:15 a.m. “HYPOGLYCEMIA—FACT OR FAN-  
to CY,” C. Conrad Johnston, M.D.,  
9:45 a.m. F.A.C.P., Indianapolis
- 9:45 a.m. “ANAEROBIC INFECTIONS,” Arthur  
to C. White, M.D., F.A.C.P., Indianapolis  
10:30 a.m.
- 10:30 a.m.  
to Questions and Answers  
10:45 a.m.
- Coffee
- Time allowed to visit exhibits
- 11:00 a.m. “THE GALLSTONE STORY,” Philip J.  
to Snodgrass, M.D., Indianapolis (by in-  
11:35 a.m. vitation)
- 11:35 a.m.  
to Questions and Answers  
11:45 a.m.
- 11:45 a.m. Section Business Meeting—Robert L.  
to Rudesill, M.D., F.A.C.P., Indianapolis  
12 Noon
- Election of Section Officers for 1974
- 12 Noon  
to Buffet Luncheon, Exhibit Hall  
1:15 p.m.

SPEAKERS



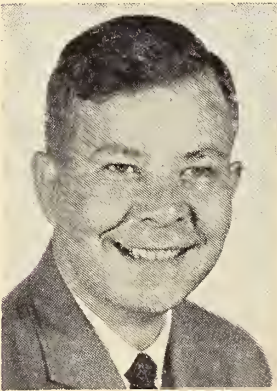
DONALD E. WOOD, M.D.  
Indianapolis  
Trustee, American Medical Association;  
past president, Indiana State Medical  
Association. M.D. degree from Indiana  
University School of Medicine in 1935.



WALTER J. DALY, M.D.  
Indianapolis  
Professor and Chairman, Department  
of Medicine, Indiana University School  
of Medicine; specialty in internal  
medicine, pulmonary disease; M.D.  
degree from Indiana University School  
of Medicine, 1955.



C. CONRAD JOHNSTON, JR., M.D.  
Indianapolis  
Professor of Medicine and Director of  
Division of Endocrinology and Metab-  
olism and Director of General Clinical  
Research Center, I. U. School of  
Medicine; specialty in internal medi-  
cine, endocrinology and metabolism;  
diplomat of American Board of In-  
ternal Medicine; graduate of Duke  
University School of Medicine, 1955.



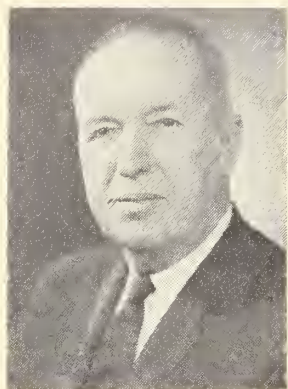
ARTHUR C. WHITE, M.D.  
Indianapolis  
Professor of Medicine and Director, In-  
fectious Diseases Division, Indiana Uni-  
versity School of Medicine; specialty  
in infectious diseases; graduate of  
Harvard Medical School, 1952.



PHILIP J. SNODGRASS  
Indianapolis  
Chief of Medical Service at Veterans  
Administration Hospital and Professor  
of Medicine, I.U. School of Medicine;  
Fellow, American College of Physi-  
cians; diplomate, American Board of  
Internal Medicine; specialty in gastro-  
enterology; M.D. degree from Harvard  
Medical School in 1953.

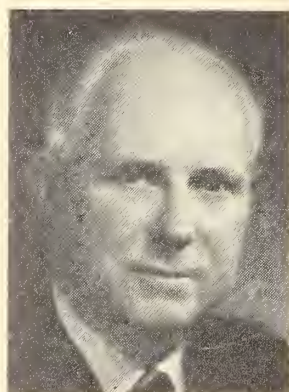


## SPEAKERS



**KENNETH G. KOHLSTAEDT, M.D.**  
Indianapolis

Master of the American College of Physicians; former vice president of medical research for Eli Lilly and Company and professor of medicine at the Indiana University School of Medicine; received American Heart Association's Award of Merit in 1959; diplomate of the American Board of Internal Medicine and a fellow of the American College of Cardiology and the New York Academy of Sciences. M.D. degree from I.U. in 1932.



**HARRISON J. SHULL, M.D.**  
Nashville, Tenn.

Clinical Professor of Medicine, Vanderbilt University School of Medicine, and in private practice of internal medicine in Nashville since 1947; Master, American College of Physicians and Regent in 1969; certified by American Board of Internal Medicine and by Sub-Specialty Board of Gastroenterology; Counsellor, AMA Section on Internal Medicine, 1971-1974; M.D. degree from Vanderbilt in 1934.



**ELMER FRIMAN**  
Indianapolis

Director, Medical Educational Resources Program, I.U. School of Medicine; president, MEDPRO Section of the Health Sciences Communication Association and is a member of the editorial board of the new HESCA Journal of Biocommunications; past president of the Association of Medical Television Broadcasters.

Wednesday, Oct. 10, 1973

### Meeting Continuing

- 1:15 p.m. Scientific Program—Moderator, Kenneth G. Kohlstaedt, M.D., M.A.C.P., Indianapolis
- 1:15 p.m. to 1:45 p.m. "ACTIVITIES OF AMERICAN COLLEGE OF PHYSICIANS—1973," Harrison J. Shull, M.D., F.A.C.P., Nashville, Tenn.
- 1:45 p.m. to 2:15 p.m. "SOCIOECONOMIC PROBLEMS OF THE INTERNIST," William A. Millhon, M.D., F.A.C.P., Columbus, Ohio
- 2:15 p.m. to 3:00 p.m. "BLOOD PRESSURE—1973," Clarence E. Grim, M.D., Indianapolis (by invitation)

### Coffee

### Time allowed to visit exhibits

- 3:15 p.m. to 4:00 p.m. "PREDICTING COMPLICATIONS OF MYOCARDIAL INFARCTION," R. Joe Noble, M.D., Indianapolis (by invitation)

### Section on Directors of Medical Education and Association of Indiana Directors of Medical Education Room 106, Convention Center

- 10:30 a.m. Annual Business Meeting
- Election of Section Officers for 1974
- 12 Noon Buffet Luncheon, Exhibit Hall

### Meeting continuing

- 1:00 p.m. "AUDIO-VISUAL AIDS IN CONTINUING MEDICAL EDUCATION," Elmer Friman, Indianapolis
- 2:30 p.m. Tour of A-V Facilities—Methodist Hospital
- 3:30 p.m. Tour of M.E.R.P.—Indiana University Medical Center



Wednesday, Oct. 10, 1973

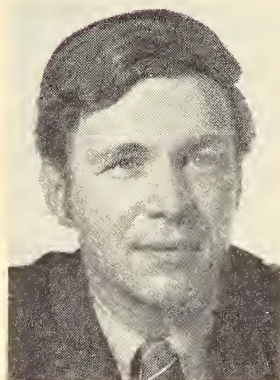
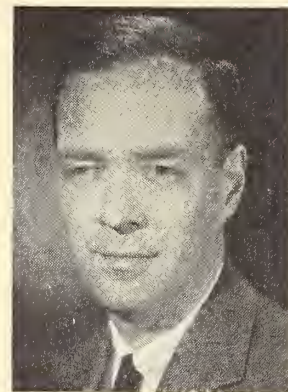
## SPEAKERS

**Section on Obstetrics and Gynecology and Indiana  
Obstetrical and Gynecological Society  
Room 210, Convention Center**

### Family Life and Sex Education

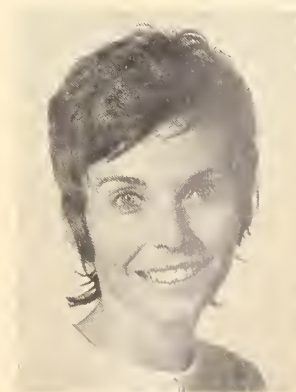
- 9:00 a.m. Introduction—R. Clay Burchell, M.D.,  
Hartford, Conn.
- 9:20 a.m. "DYADIC RELATIONSHIPS," R. Clay  
Burchell, M.D., Hartford, Conn.
- 9:20 a.m. SEXUAL PROBLEMS  
to "MALE PROBLEMS," Alan J. Wa-  
brek, M.D., Hartford, Conn.  
10:00 a.m. "FEMALE PROBLEMS," Mrs. Caro-  
lyn J. Wabrek, Hartford, Conn.
- 10:00 a.m. Coffee  
to Time allowed to visit exhibits  
10:20 a.m.
- 10:20 a.m. "SEXUAL HISTORY," R. Clay Bur-  
chell, M.D., and Mrs. Carolyn J.  
11:00 a.m. Wabrek, Hartford, Conn.
- 11:00 a.m.  
to Questions  
11:20 p.m.
- 11:20 a.m. Case Presentations and Discussion—Fac-  
ulty and Audience Participation  
12 Noon
- 12 Noon Buffet Luncheon, Exhibit Hall  
Meeting Continuing
- 1:30 p.m. "PERSONAL GROWTH," R. Clay Bur-  
chell, M.D., Hartford, Conn.  
to  
2:15 p.m.
- 2:15 p.m. "SEXUAL COUNSELING," Alan J.  
to Wabrek, M.D., Hartford, Conn.  
3:00 p.m.
- 3:00 p.m.  
to Questions  
3:45 p.m.
- Election of Section Officers for 1974

**R. CLAY BURCHELL, M.D.**  
Hartford, Conn.  
Director, Department of Obstetrics and  
Gynecology, Hartford Hospital.



**ALAN J. WABREK, M.D.**  
Hartford, Conn.  
Director of Sexual Counseling Pro-  
gram, Department of Obstetrics and  
Gynecology, Hartford Hospital; for-  
mer Assistant Professor of Obstetrics  
and Gynecology, State University of  
New York at Stonybrook.

**MRS. CAROLYN J. WABREK**  
Hartford, Conn.  
Consultant in Sexual Counseling, Hart-  
ford Hospital; member, American As-  
sociation of Marriage and Family  
Counselors; presently Ph.D. candidate  
in Human Sexuality, Marriage and  
the Family, New York University.

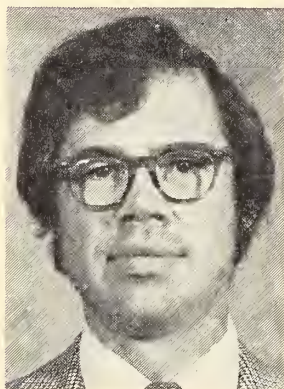




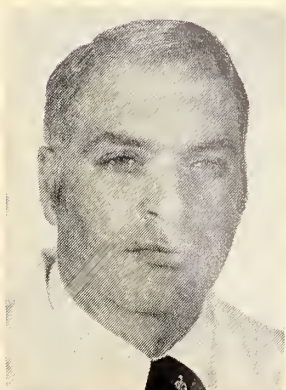
## SPEAKERS



**A. D. BRANDLING-BENNETT, M.D.**  
Atlanta, Ga.  
Chief, Investigations and Evaluations  
Section, Field Services Branch, Bureau  
of Epidemiology, Center for Disease  
Control; member Alpha Omega Alpha;  
M.D. degree from Harvard Medical  
School in 1969.



**J. WILLIAM FLYNT, M.D.**  
Atlanta, Ga.  
Chief, Birth Defects Section, Con-  
currence and Birth Defects Branch, Epidemiology  
Program, Center for Disease Control,  
and Clinical Assistant Professor of Pre-  
ventive Medicine and Community  
Health, Emory University; diplomate,  
American Board of Pediatrics; Con-  
sultant to World Health Organization  
on Congenital Malformations; M.D.  
degree from Emory University in 1960.



**JAY L. GROSFELD, M.D.**  
Indianapolis  
Professor of Surgery and Director,  
Section of Pediatric Surgery, Indiana  
University School of Medicine; Sur-  
geon-in-Chief, James Whitcomb Riley  
Hospital pediatric surgeon, Marion  
County General Hospital and St. Vin-  
cent Hospital; M.D. degree from New  
York University School of Medicine,  
1961.

Wednesday Afternoon, Oct. 10, 1973

### **Joint Session of Section on Preventive Medicine and Public Health and Indiana Association of Public Health Physicians, Inc., with Section on College Health Physicians**

#### **Room 104, Convention Center**

Robert M. Seibel, M.D., President, Indiana Association  
of Public Health Physicians, Inc., presiding

1:30 p.m. "RUBELLA—THE STATUS OF IM-  
MUNIZATION AND SCREENING  
AMONG THE CHILDBEARING  
AGE GROUP," David A. Brandling-  
Bennett, M.D., Atlanta, Ga.

"BIRTH DEFECTS — PERSPECTIVE  
FOR PUBLIC HEALTH," J. William  
Flynt, Jr., M.D., Atlanta, Ga.

Election of Section Officers for 1974

Time allowed to visit exhibits

### **Section on Surgery, Indiana Chapter, American College of Surgeons and Indiana Chapter, International College of Surgeons**

#### **Room 107, Convention Center**

1:30 p.m. "APPROPRIATE TRANSPORTATION  
AND THERAPY IN NEONATAL  
SURGICAL EMERGENCIES," Jay  
L. Grosfeld, M.D., Indianapolis

Election of Section Officers for 1974

Time allowed to visit exhibits

### **THE EXHIBITS**

We urge you to  
visit with the  
exhibitors—they are  
here to help you—and  
to bring you the latest  
information. They contribute  
to financing your convention.



Wednesday Afternoon, Oct. 10, 1973

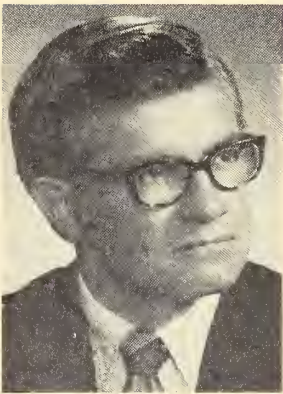
Indiana State Urology Association

Room 203, Convention Center

SPEAKERS

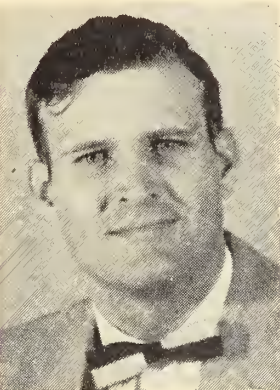
1:00 p.m. President's Report—Stafford W. Pile,  
to M.D., Indianapolis  
1:15 p.m.

GEORGE M. HALEY, M.D.  
South Bend  
M.D. degree from Stritch School of  
Medicine, Loyola University, 1955.



Report from the State:

1:15 p.m. "REFLUX REVISITED," George M.  
to Haley, M.D., South Bend  
1:30 p.m.



JOHN D. THARP, M.D.  
Muncie  
Certified by American Board of  
Urology; M.D. degree from Indiana  
University School of Medicine in 1952.

1:30 p.m. "ADRENAL CYSTS," John D. Tharp,  
to M.D., Muncie  
1:45 p.m.

PAUL E. HUMPHREY, M.D.  
Terre Haute  
Since 1947 has practiced in Terre  
Haute with practice limited to Urology.  
Served in U.S. Army from 1945 to  
1947 and was Chief of Urology at  
Wakeman General and Fitzsimmons  
General Hospital; Fellow of American  
College of Surgeons; diplomate, Amer-  
ican Board of Urology; president,  
Union Hospital staff 1973; M.D. de-  
gree from I.U. School of Medicine  
1943.



1:45 p.m. "RECENT EXPERIENCES IN NE-  
to PHOTOMOGRAPHY," Paul E.  
2:00 p.m. Humphrey, M.D., Terre Haute

Report from Executive Committee:

2:00 p.m. "NORTH CENTRAL SECTION,  
to AUA," Walter R. Vaughn, M.D., Vin-  
2:15 p.m. cennes



KIRBY TARRY, M.D.  
Indianapolis  
Fourth Year Resident in Urology, In-  
diano University Medical Center;  
served with U.S. Army in Vietnam;  
M.D. degree from I.U. School of Medi-  
cine, 1966.

Report from the University:

2:15 p.m. "HYPOSPADIAS: TYPES AND  
to TREATMENT," Kirby Tarry, M.D.,  
2:45 p.m. Indianapolis

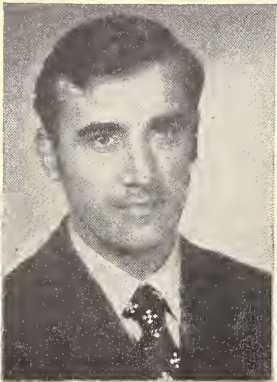
Discussant—Robert A. Garrett, M.D.,  
Indianapolis

ROBERT A. GARRETT, M.D.  
Indianapolis  
Professor of Urology, Indiana Univer-  
sity School of Medicine; M.D. degree  
from I.U., 1943.

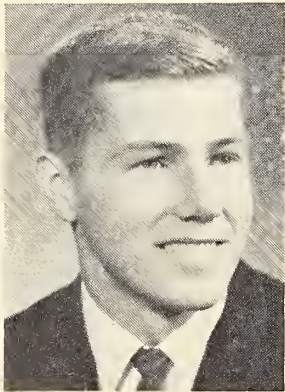




SPEAKERS



**JOHN PATRICK DONOHUE, M.D.**  
Indianapolis  
Professor and chairman, department of Urology, and chairman, Renal Transplantation Program, Indiana University Medical Center; consultant, Veterans Administration Hospital, Marion County General Hospital. Received M.D. degree from Cornell University, 1958.



**MICHAEL H. THOMAS, M.D.**  
Indianapolis  
Chief Resident in Genitourinary Disease, Indiana University Medical Center; M.D. degree from Indiana University School of Medicine, 1967.

Wednesday Afternoon, Oct. 10, 1973

- 2:45 p.m. "NEUROBLASTOMA: STAGING AND to SURVIVAL," Michael H. Thomas, M.D., Indianapolis
- 3:00 p.m. Discussant—John P. Donohue, M.D., Indianapolis
- 3:00 p.m. to Break
- 3:20 p.m. Time allowed to visit exhibits
- 3:20 p.m. Guest Lecture, Joseph J. Kaufman, M.D., to Los Angeles, Calif. (Wishard Visiting Professor—1973)
- 4:15 p.m. PYELOGRAM CONFERENCE
- to Moderator—John P. Donohue, M.D.,
- 5:00 p.m. Indianapolis

Wednesday Evening, Oct. 10, 1973

- 6:00 p.m. President's Reception and Reception for Fifty Year Club, Ballroom, Indianapolis Hilton
- 7:00 p.m. President's Dinner, Ballroom, Indianapolis Hilton
- Entertainment: Franz Benteler and His Royal Strings





**Thursday, October 11, 1973**

*(Programs are listed alphabetically)*

- 8:30 a.m. Registration continues
- 9:00 a.m. Opening of technical and scientific exhibits
- 9:00 a.m. Final Meeting of House of Delegates, Rooms 210-211, Convention Center  
Meeting of Board of Trustees and Executive Committee immediately following adjournment of House.

## **ISMA—MEDICAL ASSISTANTS' PROGRAM**

### **Room 104**

*(Program sponsored by American Association of Medical Assistants, Inc., Indiana Society)*

A program designed especially for the medical assistant and her physician-employer.

### **E.S.P. IN YOUR CAREER**

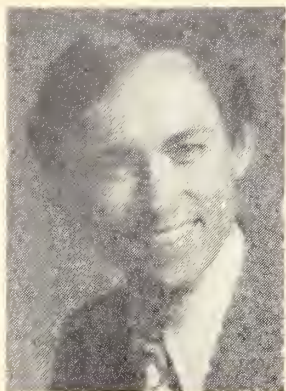
- 9:30 a.m. Welcome—James H. Gosman, M.D., President, ISMA  
Mrs. Neva Y. Arnold, Indianapolis, President, AAMA, Inc., Indiana Society, Presiding
- 9:45 a.m. "ETHICAL STRIDES TOWARD PROFESSIONALISM," Leroy Nattress, Jr., Chicago, President, Natresources, Inc.
- 10:45 a.m. E.S.P. IN THE OFFICE—Efficiency, a Standard Procedure
- 11:45 a.m. Roundtable Discussion
1. Filing or fretting?
  2. No-delay insurance
  3. Make your machines work for you
  4. Procedure manual, a requirement
  5. Legalities of telephone records
- Clayton Scroggins, Cincinnati (Business Consultant)  
Bettye Fischer, Evansville (Medical Assistant)  
William T. Leffler, M.D., Indianapolis (Physician)
- 11:45 a.m. E.S.P. in ISMA—Evaluation of Society Programs
- 12:30 p.m. "HOW THE FIELD REPRESENTATIVES CAN HELP THE MEDICAL ASSISTANT and HOW THE MEDICAL ASSISTANT CAN HELP THE FIELD REPRESENTATIVES,"  
"A LOOK AT CURRENT FUNCTIONS AND ISSUES OF ISMA,"

"PSRO," Michael H. McDermott, Indianapolis, Legislative Assistant, ISMA  
"FUTURE ROLE OF ISMA," Lowell H. Steen, M.D., Hammond.

- 12:30 p.m. Buffet Luncheon, Exhibit Hall  
Time allowed to visit exhibits  
Meeting Continuing
- 2:00 p.m. **ENDLESS SPECULATION OF THE PUBLIC**  
"HOW YOUR IMAGES ARE FORMED—YOUR IMAGE FROM THE PATIENT'S VIEW," Kenneth W. Bush, Indianapolis, Administrative Assistant, ISMA  
"THE NATIONAL PUBLIC RELATIONS PROGRAM,"  
Leo E. Brown, Chicago, Assistant to Executive Vice President, AMA  
"WHAT THE MEDICAL ASSISTANTS CAN DO FOR PUBLIC RELATIONS,"  
Lowell I. Thomas, M.D., Indianapolis
- 2:45 p.m. **EDUCATING THE SICK PATIENT**  
"WHAT IS AVAILABLE FOR USE IN EDUCATION OF THE CORONARY AND OTHER DEBILITATING DISEASED PATIENTS?"  
Charles M. Wunsch, M.D., Indianapolis  
"SOCIAL SERVICES AND OTHER SERVICES AVAILABLE TO PATIENTS,"
- 3:30 p.m. **EMPLOYER-EMPLOYEE SATISFACTION IN PRACTICE**  
"WHAT THE EMPLOYER EXPECTS OF HIS EMPLOYEE," Peter R. Petrich, M.D., Attica  
"WHAT THE EMPLOYEES EXPECT OF THEIR EMPLOYER,"  
Phyllis Jones, C.M.A., Fort Wayne  
"CORPORATE vs. NON-CORPORATE PRACTICE," Richard Fairchild, J.D., Indianapolis
- 4:15 p.m. **ESCALATING SELF TOWARD PROFESSIONALISM**  
"THE DIFFERENCE BETWEEN THE MEDICAL ASSISTANT, THE PHYSICIAN ASSISTANT AND A CERTIFIED MEDICAL ASSISTANT,"  
John J. Fauser, Chicago, AMA



## SPEAKERS



**JOHN E. PLESS, M.D.**  
Bedford

Assistant Professor of Pathology, Combined Degree Program, Indiana University, Bloomington; Lecturer, Indiana Law Enforcement Academy and Department of Forensic Studies, I.U. Coroner, Lawrence County; Pathologist at Dunn Memorial Hospital, Bedford, and Bloomington Hospital; diplomate, American Board of Pathology in Anatomic, Clinical and Forensic Pathology; M.D. degree from I.U. M.S. in 1963.

**JOHN R. RARICK**

Member of Congress from 6th Dist., Louisiana

Born at Waterford, Ind., and graduated from Goshen H.S. and Ball State University. J.D. degree from Tulane University Law School, New Orleans; admitted to Louisiana Bar in 1949. Served as an infantryman for three years in WWII; captured in Battle of the Bulge and served four months in prisoner-of-war camp, Würzburg, Germany, escaping and making way back to American lines; member Disabled American Veterans, American Legion, VFW.



Thursday, Oct. 11, 1973

### Section on Anesthesiology and Indiana Society of Anesthesiologists

#### Room 224, Convention Center

- 1:30 p.m. "THE LAST GASP," John Pless, M.D., Bedford  
Election of Section Officers for 1974  
Time allowed to visit exhibits

### Association of American Physicians and Surgeons

#### Room 227, Convention Center

- 12 Noon Buffet Luncheon, Exhibit Hall  
1:30 p.m. David Crane, M.D., Bloomington, Presiding  
"WHAT'S NEXT IN THE SOCIALIZATION OF MEDICINE?" Congressman John R. Rarick (D., Louisiana), Washington, D.C.

### Emergency Medicine Room 210, Convention Center

#### HOW THE COMMUNITY RESPONDS TO THOSE IN NEED—THE PROMISE AND REALITY

- 9:30 a.m. "IMPLEMENTING THE STATE SYSTEM—THE HASSLE IS REALLY WORTH IT," James L. Schamadan, M.D., Scottsdale, Arizona  
10:30 a.m. "REGIONALIZATION — HOW THE CITY THAT HAS EVERYTHING HELPS ITS RURAL NEIGHBORS," Roy M. Baker, M.D., Jacksonville, Florida  
11:30 a.m. Movie—"CRY FOR HELP"  
11:50 a.m. to 11:50 a.m. Buffet luncheon, Exhibit Hall  
1:30 p.m.

Time allowed to visit exhibits  
Meeting continuing

- 1:30 p.m. to 2:30 p.m. "THE SMALL COMMUNITY HOSPITAL—THE FOCAL POINT OF THE LOCAL SYSTEM,"  
Panel: Leigh Morris, Huntington  
Michael Victor, D.O., Richmond

#### COMMUNICATIONS CO-ORDINATES THE SYSTEM

- 2:30 p.m. to 3:15 p.m. "WHAT'S NEW AFTER TELEMETRY,"  
3:15 p.m. to 4:00 p.m. "YOU'RE NEVER FAR FROM THE PHONE: BUT DO YOU USE IT AS WELL AS YOU COULD?" Ron Kemmeling, Indiana Bell Telephone Company



Section on Nervous and Mental Diseases and Indiana

Psychiatric Society

Room 105, Convention Center

1:30 p.m. "SEX, PSYCHIATRY, WOMEN'S LIB AND THE COMMON COLD," Nora Scott Kinzer, Ph.D., Lafayette

Election of Section Officers for 1974.

Section on Pathology and Forensic Medicine and

Indiana Association of Pathologists

Room 106, Convention Center

PART A—Clinical Pathology—

10:00 a.m., to 4:30 p.m.

Moderator—Carlton D. Nordschow, M.D., Ph.D., Indianapolis

10:00 a.m. "POTENTIAL VALUE OF MALIG-NOLIPIN DETERMINATION IN EARLY CANCER DETECTION,"

Jose P. Resendes, Ph.D., Terre Haute

10:30 a.m. "OPERATIONAL CHARACTERIS-TICS OF THE PROGRAMMA-CHEM 1040," Donald L. Hamon,

M.D., Indianapolis

11:00 a.m. "PLANNING A COMPUTER FACIL-ITY IN PATHOLOGY," Carleton D.

Nordschow, M.D., Ph.D., Indianapolis

11:30 a.m. "CPK ISOENZYMES," David Smith,

M.D., Indianapolis

11:45 a.m. "THE CARDIO-GREEN RETENTION TEST," Robert A. McDougal, M.D.,

Indianapolis

12:00 Noon  
to Buffet Luncheon

1:30 p.m.  
Time allowed to visit exhibits  
Meeting Continuing

1:30 p.m. Moderator, Robert G. Reed, Jr., M.D.,  
to Columbus

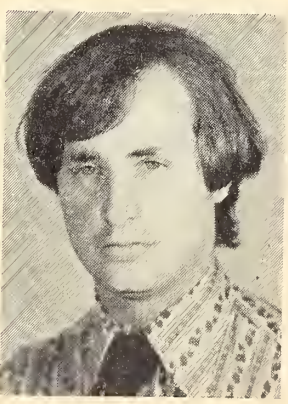
2:30 p.m.

NORA SCOTT KINZER, Ph.D.  
Lafayette  
Assistant Professor of Sociology, Pur-due North Central, Westville; member American Sociological Ass'n, Lotin American Anthropology Group of American Anthropology Ass'n; Ameri-can Ethnological Ass'n; Ph.D. degree from Purdue University in 1971.



CARLTON NORDSCHOW, M.D.  
Indianapolis  
Professor and Chairman, Department of Clinical Pathology, I.U. School of Medicine; consultant, Larue Carter Hospital and Veterans Administration Hospital; specialty in pathology; mem-ber Alpha Omega Alpha; M.D. degree from University of Iowa Medical School in 1953.

JOSE P. RESENDES, Ph.D.  
Terre Haute  
On faculty of Indiana State University; certified by the American Boards of Clinical Chemistry and Forensic Toxi-cology and A.S.C.P. Graduate of Medi-cal School of Goo in 1960; received M.C. Pathology degree from London University Postgraduate Medical School in 1962 and Ph.D. in Biochemical Pathology from University of Tennessee in 1967.



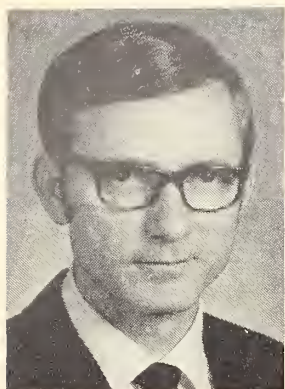
DONALD L. HAMON, M.D.  
Indianapolis  
Resident physician, Department of Clin-ical Pathology, I.U. School of Medi-cine; specialty in clinical pathology; M.D. degree from I.U. School of Medi-cine in 1973.



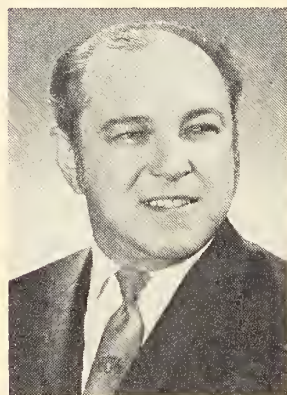
ROBERT A. McDOUGAL, M.D.  
Indianapolis  
Director of Laboratories, Winana Me-morial Hospital, Indianapolis; Assistant Clinical Professor, I.U. School of Medi-cine; specialty in pathology (C.P. and P.A.) and Nuclear Medicine (certi-fied); Fellow, ASCP, CAP; member of New York Academy of Sciences, A.A.B.B., and S.N.M.



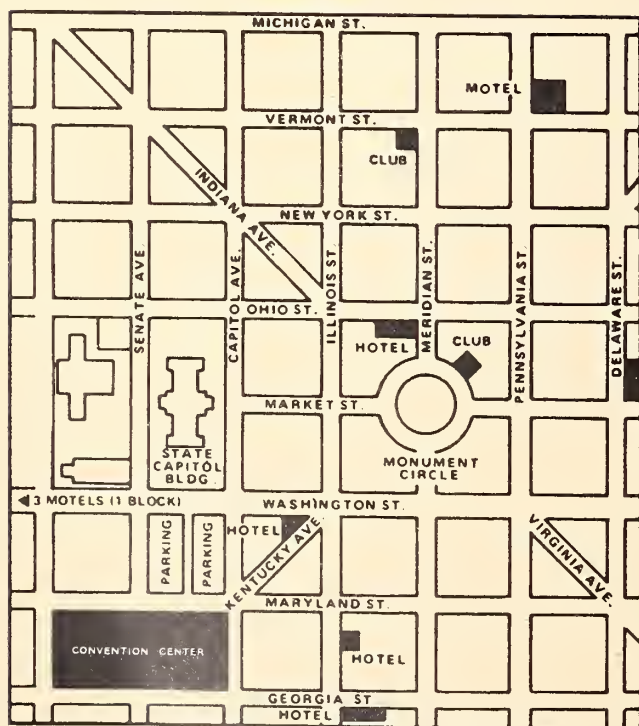
## SPEAKERS



**IRA D. GODWIN, M.D.**  
Fairfax, Va.  
Assistant Clinical Professor of Pathology, The George Washington University, Washington, D.C., and Director of Laboratories, Northern Virginia Pathology Laboratories; President, Virginia Society for Pathology, 1972-73; M.D. degree from University of North Carolina Medical School in 1955.



**VICTOR H. MULLER, M.D.**  
Indianapolis  
On faculty of Indiana University School of Medicine; Medical Director of Community Blood Bank of Marion County; specialty in pathology—blood banking and immunohematology; M.D. degree from Indiana University School of Medicine in 1951.



**Downtown Indianapolis**

Thursday, Oct. 11, 1973

- 1:30 p.m. "NUCLEAR PATHOLOGY," Ira D. Godwin, M.D., Fairfax, Va.
- 2:00 p.m. "RADIOIMMUNOASSAY FOR HEPATITIS B. ANTIGEN—IMPACT ON BLOOD BANKING," Victor H. Muller, M.D., Indianapolis
- 2:30 p.m. to Coffee Break and Time to Visit Exhibits
- 3:00 p.m. Moderator, James W. Smith, M.D., Indianapolis
- 3:00 p.m. to
- 4:30 p.m. "ANAEROBIC BACTERIOLOGY, ONE YEAR'S EXPERIENCE," James W. Smith, M.D., Indianapolis
- 3:30 p.m. "DETECTION OF GRAM-NEGATIVE SEPSIS BY ENDOTOXIN TEST," T. Max Warner, M.D., Indianapolis
- 4:00 p.m. "MICROTUBE IN-VITRO SUSCEPTIBILITY TESTING," Benjamin M. King, M.D., Columbus
- Election of Section Officers for 1974

### PART B—Nuclear Medicine Workshop— 8:00 a.m. to 5:00 p.m., Methodist Hospital

#### "COMPETITIVE PROTEIN BINDING AND RADIOIMMUNOASSAY,"

James MacKenzie, M.D., Indianapolis  
Ira B. Godwin, M.D., Fairfax, Va.

Sponsored by Indiana Association of Pathologists

This workshop is designed for teams of pathologist and technician and will include lectures on the above subjects. In addition, pathologists will be instructed on clinical application and interpretation and technicians will participate in a wet workshop in which they will complete a typical radioimmunoassay procedure. Workshop and lectures will be at Methodist Hospital. Participants will be transported to Convention Center at noon for lunch and to hear Dr. Godwin's paper at 1:30 p.m. At 2:00 p.m. technicians will be returned to Methodist Hospital to complete wet workshop and Pathologists will remain at Convention Center to attend afternoon Attendance is by advance registration. The workshop session of Part A of Section meeting in Pathology. is sponsored by I.A.P. and there is no charge to participants. Attendance is limited to 30 teams of pathologists and technicians.



Thursday, Oct. 11, 1973

**Section on Radiology and Indiana Roentgen  
Society, Inc.**

**Room 225, Convention Center**

- 9:30 a.m. Executive Committee Meeting  
Election of Section Officers for 1974
- 10:30 a.m. Panel Discussion—David C. Gastineau,  
to M.D., Fort Wayne, Chairman  
12 Noon

**RADIATION THERAPY SEMINAR—  
MANAGEMENT OF HODGKIN'S  
DISEASE**

**"STAGING AND CLASSIFICATION,"**

Jack Horvath, M.D., Lafayette

"SPECIAL PROCEDURES IN DI-  
AGNOSIS AND STAGING," Paul L.  
Webster, M.D., Lafayette

"RADIATION THERAPY," Frank  
Pairitz, M.D., Indianapolis

"Chemotherapy," David C. Gastineau,  
M.D., Fort Wayne

"SUMMATION," Homayoon Shidnia,  
M.D., Indianapolis

- 12 Noon Buffet Luncheon, Exhibit Hall

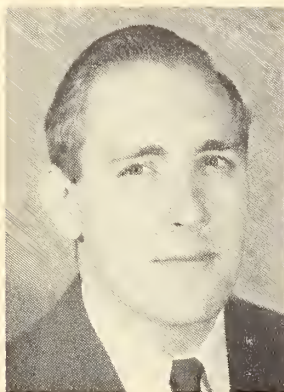
- 1:15 p.m. "FILM READING SESSION," James G.  
to Lorman, M.D., Fort Wayne

1:45 p.m.

- 1:45 p.m. "THE STATIC AND DYNAMIC  
to BRAIN SCAN," L. Ray Stewart,  
2:30 p.m. M.D., Evansville, and M. Jack Powell,  
M.D., Fort Wayne

- 2:30 p.m. DIAGNOSTIC RADIOLOGY  
to 1. "TRAFFIC CONTROL AND  
4:00 p.m. SCHEDULING IN THE X-RAY DE-  
PARTMENT," John Knote, M.D.,  
Lafayette and William J. Miller, M.D.,  
Lafayette
2. "ANGIOGRAPHIC INVESTIGA-  
TION OF GI BLEEDING," Barbara  
Workman, M.D., Muncie
3. "SEAT BELT INJURIES," John R.  
Dehner, M.D., Richmond

**SPEAKERS**



**DAVID C. GASTINEAU, M.D.**  
Fort Wayne

Associate Professor of Radiology, I.U.  
at Fort Wayne; specialty in radiother-  
apy; member American College of Ra-  
diology and Radiology Society of  
North America; M.D. degree from  
Indiana University in 1947.



**M. JACK POWELL, M.D.**  
Fort Wayne

On faculty of Indiana University, Di-  
vision of General and Technical Stud-  
ies, Fort Wayne, X-Ray Technician  
Training Program; chairman of De-  
partment of Radiology at St. Joseph's  
Hospital, Fort Wayne, since 1963; cer-  
tified by American Board of Radiology  
in 1954; M.D. degree from Hahne-  
mann Medical School in 1943.



**WILLIAM J. MILLER, M.D.**  
Lafayette

Radiologist, Lafayette Home Hospital;  
M.D. degree from Indiana University  
in 1960.

**THE EXHIBITS**

We urge you to  
visit with the  
exhibitors—they are  
here to help you—and  
to bring you the latest  
information. They contribute  
to financing your convention.



# *Program — Woman's Auxiliary to the Indiana State Medical Association*

**President**—Mrs. Willis W. Stogsdill, Indianapolis

**General Chairman of Women's Activities**—Mrs. Richard B. Schnute, Indianapolis

**Co-Chairman of Women's Activities**—Mrs. Richard C. Powell, Indianapolis

**Reservations**—Mrs. Richard A. Brickley, Indianapolis

**Golf Day**—Mrs. Thomas W. Johnson, Indianapolis

**Co-Chairmen of Art and Hobby Show**—Mrs. Harry Siderys and Mrs. Harold G. Halbrook, Indianapolis

**LaTour Luncheon**—Mrs. David E. Smith, Indianapolis

**Wednesday Luncheon**—Mrs. Edward H. Daley, Indianapolis

**Dinner - Theatre Party**—Mrs. Berj Antreasian, Indianapolis

## **Monday, October 8, 1973**

9:30 a.m. Art and Hobby Show, Exhibit Hall  
to  
4:30 p.m.  
9:30 a.m. Registration Begins, Exhibit Hall  
11:00 a.m. Golf Tournament, Hillcrest Country Club  
12 Noon Chef Demonstration and Gourmet Luncheon—La Tour Restaurant

## **Tuesday, October 9, 1973**

9:30 a.m. Art and Hobby Show, Exhibit Hall  
to  
4:30 p.m.  
9:00 a.m. Judging and Popular Voting  
to  
12:00 noon  
9:30 a.m. Registration Continues  
9:30 a.m. **QUALITY OF LIFE PROGRAM**  
Room 211-212, Convention Center  
12 Noon IMPAC Luncheon, Ballroom  
2:00 p.m. **QUALITY OF LIFE PROGRAM** Con-  
to tinues  
4:00 p.m.  
5:30 p.m. Social Hour (Cash Bar) Atkinson Hotel  
Ballroom  
6:30 p.m. Dinner - Theatre Party, Atkinson Hotel  
Ballroom  
The Tudor Troupers will present "Marriage-Go-Round."

## **Wednesday, October 10, 1973**

9:30 a.m. Art and Hobby Show, Exhibit Hall  
to  
4:30 p.m.  
9:30 a.m. Registration Continues  
9:30 a.m. Open Board Meeting, Woman's Auxiliary  
to the Indiana State Medical Association,  
Room 225  
Mrs. Willis W. Stogsdill, president, pre-  
siding  
11:30 a.m. Social Hour (Cash Bar)  
12 Noon Luncheon, Room 224  
2:00 p.m. Workshop on Abused and Battered Child  
to Syndrome, and Membership  
4:00 p.m.  
6:00 p.m. President's Reception and Reception for  
Fifty Year Club, Ballroom, Indianapolis  
Hilton  
7:00 p.m. President's Dinner, Ballroom, Indianapo-  
lis Hilton  
Entertainment—Franz Benteler and His  
Royal Strings

## **Thursday, October 11, 1973**

9:30 a.m. Art and Hobby Show, Exhibit Hall  
12 Noon Indiana State Prayer Luncheon  
Honorary Chairman—Mrs. Otis Bowen  
Speaker—Mrs. Norman Vincent Peale



# Reports of Officers

## Executive Secretary

The following is a resume of the action taken by the 1972 House of Delegates and disposition of those matters.

Items from the printed report of the President.

Item #2. Concerning the restudy of the structure of commissions and committees of the Association. This matter is still under study.

Item #3. Suggestion that the immediate past-president become a member of the Executive Committee and of the Board of Trustees was referred to the Committee on Constitution and Bylaws which will report on this at this session.

Item #4. Concerning election of officers and the timing thereof has been referred to the Commission on Constitution and Bylaws.

Item #7. Concerning budgeting for public relations. This has been referred to the Board of Trustees and the Commission on Public Information. Public Information has reported on this item at this session of the House.

Item #8. Concerning further service programs to the members of the Association has been referred to the Commission on Medical Economics and Insurance.

Item #9. Concerning membership on reference committees. This matter has been referred to the Commission on Constitution and Bylaws.

Item #10. Concerning computerization of many programs in the state headquarters and investigation of use of computers has not been investigated any further at this time.

Resolution 72-19A. This resolution adopted by the 1972 House of Delegates in lieu of resolution 71-3 and 72-19 were considered together by the Board and reported at the 1972 session of the House. Since that time, it has been referred to the Committee on Finance of the Board of Trustees.

*Supplemental report of the President-Elect*, in which he made a recommendation that interns and residents have a separate section and be permitted to send a voting delegate to the House of Delegates. This has been referred to the

Commission on Constitution and Bylaws which reported both last year and will report again this year.

*Report of the Commission on Governmental Medical Services* concerning the establishment of a review committee to handle review of third-party claims on fees was referred to the Board of Trustees.

*Commission on Public Health* report. The house recommended that the Commission in its next report include a section on drugs, all drugs and not just marijuana. Also that this Commission clarify its position on smallpox vaccination in its next report.

It is also recommended that the Commission do a statewide survey on resolution 71-5, a statewide moratorium on amphetamine drugs.

These recommendations were referred back to the Commission on Public Health which will report on them at this session of the House.

*Report of the Commission on Medical Economics and Insurance.*

The report was adopted by the House with specific recommendations as follows:

Item #1. The items dealing with professional review and/or fee review committees and the portion dealing with Blue Shield are referred to the Board of Trustees and were so referred.

Item #2. Recommendation dealing with the establishment of a professional review and/or fee review committee not be adopted but be made available to the Board of Trustees for their deliberation. This has been referred to the Board.

Item #3. Recommended that the Commission make available more than one type of a contract form for use by physicians and their patients to establish the fees to be charged to the patient. The Committee has made such recommendation and report for this session.

*The Joint Report from the Commission on Medical Economics and Insurance and the Future Planning Committee.*

Dealing with the recommendation that the Board of Trustees be directed to establish a mechanism for a statewide corporation to provide for professional review was referred to the Board of Trustees.

*Report of the Commission on Medical Education and Licensure.*

The Committee recommended the

establishment of a special membership category known as "Distinguished Members." This has been referred to the Commission on Constitution and Bylaws which will report upon that at this session.

The Commission's recommendation for a model medical practice act was referred back to the Commission for further study and for a legal draft to be prepared and presented to the 1973 session of the House of Delegates. The Committee will make a report on this at this session.

*Report of the Commission on Special Activities.*

The Commission report contained a resolution dealing with the subject that the Indiana State Medical Association endorse the formation of group medical practices in the state of Indiana, etc.

This report was referred to the Board of Trustees.

*Proper Certification of Delegates.*

The Committee on Rules and Order of Business brought to the attention of the House that some of the credentials of the delegates are not properly signed by secretaries of the county medical societies prior to the annual convention and in accordance with Chapter 4, Section 2 of the Constitution. This was referred to the Board of Trustees which has issued the following ruling, "For seating of delegates at the 1973 and other sessions of this House credentials cards will be forwarded to the secretary of each component county medical society who is supposed to put thereon the name of the delegate and his alternate and properly sign this credential card which must be presented to the credentials committee of the House before being seated as a delegate."

*Report of the Special Reference Committee.*

The Special Reference Committee listed 13 items, all of which have been referred to the Future Planning Committee.

Recommendation #2 that the Special Reference Committee be held annually and this was referred to the Board of Trustees who feel that this should be on a biennial basis rather than an annual basis.

Recommendation #3 concerning circularization of county societies on pertinent material so that they may too consider implementation. These have been sent to the county medical societies.



*Resolutions.*

72-1 Dealing with the Indiana Medical Historical Foundation, was referred to the Board of Trustees and the President was authorized to appoint a special committee to work with Dr. Bonsett and his group. In addition, the Board of Trustees and the Board of Directors of the Medical Education Foundation of Indiana appropriated \$10,000 from funds to assist Dr. Bonsett in his efforts.

72-2 Was referred to the Commission on Legislation.

72-3 Substituting TB skin tests in lieu of chest x-rays, was referred to the Commission on Legislation.

72-4 Fiscal note required on resolutions calling for expenditure of money, has been referred to the Commission on Constitution and Bylaws.

72-5 Creating SAMA representation to the House of Delegates. This has been referred to the Commission on Constitution and Bylaws.

72-7 Medical Department in the Board of Corrections. This was referred to the Commission on Legislation. It also was a part of the Governor's program and it became a law.

72-9 Changes name of the section on general practice to section on family practice. This change was made in the Bylaws of the Association.

72-10 Utilization of peer review mechanisms. This resolution has been followed and the matter has been referred back to the county medical societies and doctors have been advised of their right to enter into a prior agreement with patients regarding the fee for services to be rendered.

72-11 Cost of hospital care. This was on the agenda for the joint meeting of the Executive Committees of the Hospital Association and the Indiana State Medical Association, but through conflict of dates, the meeting has not yet been held.

72-14 Was referred to the Commission on Public Health and they are reporting their findings back to the House at this session.

72-15 Medical liability legislation. This was referred to the Commission on Legislation and a bill was drafted and introduced in the 1973 session of the legislature but failed to pass.

72-16 Nomination of ISMA officers and AMA delegates. This was adopted by the House and will become effective and operative at the 1973 session of the House of Delegates where nominating speeches will be limited to five

minutes, etc.

72-19A Calling for notification of the congressional delegation from Indiana to continue supporting the fee for service and traditional doctor-patient relationship and state licensure of medical practitioners was discussed with the congressional delegation.

The other resolve, that \$3.00 per member be, through an increase in dues, set aside to provide adequate legal counsel for class action suits, was referred to the Board of Trustees Finance Committee.

72-20 Constitutional amendment creating the office of Speaker and Vice-Speaker of the House was referred to the Commission on Constitution and Bylaws which is reporting at this session.

*Membership.*

Membership in the Indiana State Medical Association has shown the largest growth the first six months of 1973 of any year during the past ten years.

I have prepared an analysis of membership trends over the past ten years and you will notice that, as of July 31, 1973, we are showing a gain of 99 new members for the year. The highest previous gain was in 1969 with an increase of 50 members.

The chart also indicates the number of AMA members as of 1973, and you will notice here that we have gained 113 AMA members over the same period last year. As of July 31, we have lost 333, but this is 14 fewer than at the same period last year. President Gosman at the beginning of this year appointed a membership committee with Dr. Peter R. Petrich, immediate past-president, as chairman. This committee is actively working and trying to interest non-member physicians in the ISMA and AMA for joining or rejoining, whichever the case might be. We hope that this effort will be a successful one showing a good increase in membership at the end of the current year.

Again, I would like to suggest that those counties that have interns and residents in their midst make an effort to provide membership for them in the county medical society as well as the State Medical Association. Under the present Constitution and Bylaws of the Indiana State Medical Association and the American Medical Association, interns and residents are now being

given the same active membership as others at a reduced membership fee—namely, \$15.00 for ISMA and \$20.00 for the AMA.

ANALYSIS OF MEMBERSHIP  
TREND OVER PAST 10 YEARS

Year	ISMA		AMA		ISMA Members Non-AMA Members
	7/31	Gain Loss	7/31	Gain Loss	
1962	4307	+ 9	4184	+ 6	123
1963	4330	+23	4222	+38	108
1964	4331	+ 1	4225	+ 3	106
1965	4356	+25	4255	+30	101
1966	4367	-11	4254	- 1	113
1967	4356	-11	4180	-26	176
1968	4400	+44	4246	+66	154
1969	4450	+50	4301	+55	149
1970	4457	+ 7	4291	-10	166
1971	4489	+32	4236	-55	253
1972	4526	+37	4179	-57	347
1973	4625	+99	4292	+113	333

ANNUAL MEETING:

For your information, I am submitting a list of companies which have exhibited with the Association for the past several years, but who have notified the Headquarters that they will not exhibit this year. They are:

Burroughs Wellcome, Co., Dome Laboratories, Eaton Laboratories, Lederle Laboratories, Ortho Pharmaceuticals, Parke-Davis & Company, Roche Laboratories, Searle Laboratories, Smith Kline & French Laboratories, and USV Pharmaceutical Corporation.

As of this report, 28 spaces in the exhibit hall have been sold to 25 companies for a total income of \$7,900.

Under the circumstances, the growing lack of interest in exhibiting is creating each year the need for increased funds from the treasury of the Association to offset the costs of the Convention.

CHAMPUS:

From June 1972 through June 30, 1973, the Champus department paid 18,499 claims. These claims included physicians claims, drugs and outpatient hospital. Total outlay of funds was \$1,459,762.07.

With the elimination of obstetrical and gynecological services at Fort Benjamin Harrison and Grissom Air Force



Base, all active duty dependents requiring this care will now come under the CHAMPUS program and claims will be processed through ISMA headquarters, which, of course, promises a greater claim load during the forthcoming year.

#### FIELD SERVICE:

With the employment of a legislative assistant, the field staff of the Association was able to give more time to other than legislative affairs of the ISMA on a continuing basis. They, however, continue to assist in legislation by keeping physicians informed on current status of legislation and working in conjunction with the legislative assistant in gathering data and information from the field for use by the Commission on Legislation.

In addition, the field staff has assisted with gathering survey material at the specific request of Commissions, and are currently making contact with county societies and physicians to ascertain physician contact with members of the communications field throughout Indiana, so that more effective reporting on ISMA news releases and information emanating from the Headquarters Office can be developed.

Current plans for the field staff call for more active staff help in planning District meetings, membership promotion, and continued liaison with county societies and individual physicians.

#### LEGISLATION:

Through a full time legislative assistant, the Association has benefitted from a much closer liaison, year round, with members of the General Assembly, legislative study groups and the ISMA membership at large.

This department will be keeping county medical societies up to date on the status of legislation through periodic reports and has also initiated a new bulletin on medical political activity through the IMPAC News. This new department, we believe, will give the ISMA a more effective role in its lobbying activities during the actual session.

In addition to legislative activity at the local and state level, this department will keep itself apprised of legislative actions at the Federal level and maintain close contact with the AMA headquarters and the AMA Washington office.

The forthcoming year will see greater concentration on educating the membership to the value of membership in IMPAC and AMPAC and an effort to

inform the membership of the effect and results of their political action dollars.

#### PUBLIC RELATIONS:

Public relations is involved in all of the activities of the Association and is not necessarily confined to the printed word in newspapers or the spoken pictorial presentations on radio and television.

The Commission on Public Information of the ISMA is continuously working toward programs which can present the true picture of organized medicine and the practicing physician. As everyone in the profession knows, there has been much irresponsible reporting of facts and figures on health care costs and the current medical care delivery system. One major example of this was the national program aired by NBC entitled "What Price Health?"

In an effort to counteract such misleading and grossly inaccurate reporting, the ISMA Public Information Commission is working toward the development of a professional Speakers Bureau which can represent, on a pre-scheduled basis, the ideas and philosophies of the medical profession and present true facts and statistics of the socioeconomic scene to lay clubs and organizations throughout the state.

The byproduct of such programming with the advance news stories on appearances, news coverage at the site of the speaker's engagement and followup stories in public print, as well as the word-of-mouth communication of the audience with those not in the audience, constitutes the ingredients of an *action program* with resultant good public relations for the profession. It is our hope that the Association will see fit to endorse the program and create funds for its development.

The Association continued to act as a clearing house for information to the Hoosier public on an untold variety of subjects from questions on abortion clinics to providing information to a sixth grader for a report on the damaging effects of drug usage. The variety of requests is limitless.

#### USE OF BUILDING:

Use of the building is increasing annually, with meetings being held throughout the week and on Sundays by ISMA Commissions, Committees, Auxiliary Committees and committees of health related groups such as medical specialty

groups, Regional Medical Program, voluntary health associations and medical student groups.

A portion of the staff is on a six to six-and-one-half-day work schedule a greater portion of each year due to the increased programming by the Board and the Commissions.

Currently the building is at capacity usage with the current staff and space for necessary mechanical equipment to conduct the affairs of the Association.

In conjunction with the constant usage of facilities by the many groups and committees, is the limited capacity of the parking area, and the lack of adequate storage space.

Study is now being undertaken by the Board to determine courses for possible expansion in view of future needs which can be foreseen from the need for more staff to act as liaison with Comprehensive Health Planning, manage the new Continuing Medical Education Accreditation Program, perhaps administrate the forthcoming PSRO and other government programs which may appear and conduct the administration of other developing programs initiated by Commissions and the Board of Trustees.

#### OTHER PROGRAMS:

In addition, following are programs being planned or now in effect. Some of them will have a direct effect on the additional utilization of Headquarters space and additional manpower needs for the ISMA.

The American Medical Association will no longer credit institutional and organizational programs designed for continuing medical education in states and local communities. They are going to confine their efforts to national organizations and groups. As a result of this, the Commission on Medical Education and Licensure of the Indiana State Medical Association has proceeded with a plan for accrediting institutions and organizations in Indiana and has received from the American Medical Association provisional approval for one year.

Essentially, an organizational institution wanting to receive accreditation will complete a rather detailed questionnaire on its programs and then will be visited by a team of physicians to make an on-site evaluation. Their accreditation will be determined on the basis of five different classifications ranging from a full accreditation with the last classification as non-accredited.

This program is a voluntary program



for institutions and physicians and will in no way affect a physician's membership status with the Indiana State Medical Association. As you know, two or three states in the country have instituted continuing medical education as a prerequisite to membership in their respective state medical organizations, or for license renewal.

Physicians completing courses which are accredited by the Indiana State Medical Association, 150 hours over a three-year period, will be eligible for the AMA's Physician Recognition Award and will also have their particular award sealed with a special ISMA accreditation emblem and will also receive a special membership card identifying them as a Distinguished Member of the organization.

#### MALPRACTICE INSURANCE:

The Commission on Medical Economics and Insurance is currently working on a plan at the request of the Board of Trustees of the ISMA which has the potential of establishing for the state of Indiana an ISMA for-profit corporation which initially would deal with managing malpractice insurance for members of the Association.

Such a plan has been successful in Florida with the Florida State Medical Association participating. Involved would be the ISMA owning 49% of the stock in the company with the broker owning 51% of the stock. It is anticipated that under the plan the State Medical Association could earn from \$75,000 to \$100,000 a year from the program which, in effect, could assist in the budget requirements of the ISMA. With the ISMA managing a malpractice insurance program for the doctors, premiums could be lower, and many of the malpractice cases could be arbitrated outside of courts, which would block much of the unnecessary litigation. The Commission and the Board of Trustees is enthusiastic about the idea.

#### BOOKLETS:

Since October the ISMA has produced two leaflets—one on Medicare which

explains to the patient some of the true facts about the Medicare program. Many Medicare patients take for granted that all their bills will be paid under the program. The leaflet is an effort to clarify this for the patient so that he will understand the true facts about the Medicare program. In addition, the ISMA also wrote and produced a leaflet on Medicaid which was designed to help the Medicaid patient understand the rules and regulations of his medical care. These leaflets have been widely ordered. We find that the physicians using them in their offices are highly appreciative.

In addition to these leaflets, the Commission on Public Information is currently planning the development of a leaflet which would explain to the patient that health insurance plans dictate the principles of the policies within the plans and do not necessarily mean that when a patient purchases an insurance policy that he is totally covered. It will attempt to clarify for the patient the fact that, even with insurance, coverage in certain areas and the costs are not total.

The commission developed and published in The Roster issue of the *ISMA Journal*, a booklet on how to avoid malpractice and legal problems. It is an excellent guide and it is hoped that members will utilize it as a desk reference.

#### TEL-MED:

The Association also installed Tel-Med telephone equipment in the headquarters office. There are 10 telephone lines which come into the headquarters office on which any person interested in any of the 100 subjects can call in and hear a brief three- to five-minute medically approved tape on the subject requested. Currently involved is the Marion County area and about 9 or 10 counties in the immediate surrounding toll-free area of Indianapolis. The program has met with outstanding success.

From March 22, 1973, the date for inception of the program, to June 30, the Tel-Med exchange received 38,947 calls. 5,170 of these calls were recorded on weekends, during which time the exchange is not in operation.

The program has necessitated the hiring of an operator to handle calls.

#### RETREAT:

In mid-March, the Commission on Medical Education and Licensure con-

ducted the third annual Retreat with medical students and I.U. Faculty in Brown County in a two-day session. The purpose of this meeting, as in other meetings, is to, in an informal atmosphere, discuss with the students and the faculty medical education in general. The turn-out for the meeting was excellent and the outcome of this meeting was that students showed interest in getting more information on the administrative side of medical practice. The impact of this meeting is that the medical school listens, the medical school participates, and many of the recommendations emanating from this meeting eventually filter into the curriculum and programs for the medical students at I.U. Much interest was expressed this year in the problems of communities wanting physicians. Such a program, too, alerts the student to organized medicine and its problems and objectives which is an indirect benefit to ISMA.

#### INSURANCE PROGRAMS OF THE ASSOCIATION:

The disability income program and the life insurance program continue to grow. More and more physicians are participating in these programs, which of course, are direct benefits.

#### EMERGENCY MEDICAL SERVICES:

With the co-operation of the Indiana State Nurses Association, the Indiana Hospital Association, Regional Medical Program, the State Board of Health, and the Governor's Office, the Commission on Emergency Medical Services held a one-day conference on Emergency Medical Services. Attending were 650 people from throughout Indiana, representing all groups involved in emergency services throughout Indiana.

Emphasis in the program was to coordinate the efforts of these various groups in instituting an effective plan for Indiana through legislation. Hopefully, the Conference will produce positive steps by the legislature with resultant benefit to the profession, hospitals and the Indiana public.

#### OTHER SERVICE OF THE ASSOCIATION:

The last three trips which have been endorsed by the ISMA, which are international tours, have been completely filled by Indiana physicians and their wives and families marking them as a desired service by the membership.



Your secretary has deliberately mentioned these programs which may well be enumerated in other reports to the House. The membership should be aware of the fact that they are the result of long hours of deliberation and planning by the Commissions and Committees of the Association and continuous follow-up by the ISMA staff. As the programs increase, so grows the demand for personnel.

I would also observe that the initiation of new programs is developing with more intensity each year. The Association has gone far beyond the stage of philosophizing and offering advice on matters of importance in the medical and health field. The Association, like every other organization, has found it necessary to become actively involved in issues and programming for its own benefit, and in those areas where it rightfully has the responsibility and authority to participate.

This must continue, since, as has been demonstrated during the past decade, if medicine does not remain active and aggressively energetic in its own behalf, third parties will and do assume these responsibilities, and not necessarily in the best interest of the profession.

JAMES A. WAGGENER,  
*Executive Secretary*

## Treasurer

The audit for the fiscal year ending September 30, 1972, was published in detail in the March 1973 *Journal*. Inasmuch as the current fiscal year ends September 30, 1973, the audit will not be available for presentation to the House at this time.

I have prepared a statement of financial condition of our Association for nine months of the current fiscal year which appears below. It appears at this time your Association is in good financial position.

HUGH K. THATCHER, JR., M.D.  
*Treasurer*

## Chairman of the Board Report

The Trustees met immediately following the adjournment of the final session of the 1972 House of Delegates for the purpose of organizing. Dr. Gilbert M. Wilhelmus, Evansville, was elected Chairman; Dr. Vincent Santare, Munster, Dr. Donald Kerr, Bedford, were elected members of the Executive Committee.

I wish to express my gratitude to the members of the Board for electing me Chairman. The experience obtained from this position has been interesting and

rewarding, and has given me a much broader view of the workings of organized medicine in our State Association. I wish to express my appreciation to the members of the Board for the many hours of tedious work. Also, I wish to express my appreciation for the staff at the ISMA building, the field men, the legislative assistant, and Mr. James A. Waggener.

During the past year the Board has met many times and worked very hard. The majority of our meetings were two-day meetings. The meetings were set up as follows: discussion, informative outside speakers, reports of the Commissions, and policy statements. I shall attempt to highlight some of the significant accomplishments. Much of our time has been spent in discussing the involvement of the government in medical care, particularly PSRO.

## NOVEMBER 19, 1972, MEETING

The AMA Delegates reviewed for the Board resolutions and committee reports which would come before the AMA House of Delegates. There was much discussion by the Board and Delegates on the enormous volume of business to be transacted. Donald E. Wood, M.D., AMA Trustee, reported that the American Medical Association projected sav-

## INDIANA STATE MEDICAL ASSOCIATION Statement of Financial Condition at June 30, 1973

ASSETS	General & Journal	Building Fund	Medical Defense	Student Loan	TOTAL ALL FUNDS
Cash in banks-operating .....	23,534	2,255	805	—	26,594
Cash in banks-interest bearing .....	20,000	6,852	19,086	19,190	65,128
Short term treasury bills .....	288,247	150,150	—	—	438,397
Accounts receivable .....	24,905	357	1,367	—	26,629
Prepaid expenses .....	10,925	1,352	—	—	12,277
Long term investments .....	85,977	—	25,095	20,810	131,882
Property-less reserve for depreciation .....	20,873	403,627	—	—	424,500
Total Assets .....	<u>474,461</u>	<u>564,593</u>	<u>46,353</u>	<u>40,000</u>	<u>1,125,407</u>
LIABILITIES AND FUND BALANCES					
Accounts payable .....	2,162	691	—	—	2,853
Property taxes accrued .....	—	2,390	—	—	2,390
Deferred annual meeting .....	955	—	—	—	955
Dues payable to AMERF .....	20,070	—	—	—	20,070
Non-interest bearing notes .....	—	20,925	—	—	20,925
Advances from AMA .....	9,278	—	—	—	9,278
Deferred dues income .....	210,742	—	—	—	210,742
Total Liabilities .....	<u>243,207</u>	<u>24,006</u>	<u>—</u>	<u>—</u>	<u>267,213</u>
Fund Balances October 1, 1972 .....	206,915	497,414	43,350	40,000	787,679
Excess income nine months .....	24,339	43,173	3,003	—	70,515
Fund Balances at 6/30/73 .....	<u>231,254</u>	<u>540,587</u>	<u>46,353</u>	<u>40,000</u>	<u>858,194</u>
Total Liabilities and Fund Balances .....	<u>474,461</u>	<u>564,593</u>	<u>46,353</u>	<u>40,000</u>	<u>1,125,407</u>



ings of \$840,000 in its reorganization plan of councils and committees. A discussion was held on the possibilities of who is to fill the position of State Health Commissioner—at this time no successor has been found.

Two representatives from the Health Services and Mental Health Administration, Department of Health, Education, and Welfare, reported to the Board. They wished for Indiana to be one of five states in a test project which would involve the use of uniform reporting forms for physicians from the Medicare and Medicaid programs. Fees for procedures would also be reported on the forms. Following lengthy discussion and questions, the Board voted not to participate in the project.

President Gosman reported that four physicians from the U. S. Public Health Service had been assigned to the staff of the Marion County Neighborhood Clinics. He also stated that the Marion County Medical Society Executive Committee had approved the service in accordance with regulations, and the program requested the approval of the ISMA. The Board approved the plan contingent upon the approval of the Marion County Board of Trustees.

Dr. Vincent Santare reported on the Professional Standards Review Organization. The all-encompassing bill on health care delivery deals with such subject matters as: definition of a qualified organization to form PSRO, authority for hospital admissions, patient and physicians profiles, review of qualifications, use of Hospital Review Committee, certification of in-patient care, grounds for exclusion, and others. This matter was then referred to the Board Committee for study and implementation of governmental medical programs.

It was noted that legislation requiring plaintiffs in malpractice cases to post bond will be introduced in the state legislature on the action of the Board. The plaintiff will be required to deposit a \$500 surety bond. Should the plaintiff lose the case, he will be required to pay the court costs.

#### JANUARY 20-21, 1973, MEETING

The Board went on record extending the services of the headquarters offices to the speciality societies. The Board passed a motion unanimously whereby the Women's Auxiliary to ISMA received credit for all AMA-ERF collections in the state. This should place the auxiliary in a better position of competition with other state auxiliaries.

The Board sent letters to all Indiana congressmen informing them of the Federal Drug Administration's action in regard to the new regulations which continually remove drugs from the market.

Dr. Donald Wood, AMA Trustee, reported that the AMA is asking state societies to do nothing about organizing PSROs. At this time there has been no director named in the Department of Health, Education, and Welfare.

The discrimination against physicians under the new Phase III program was discussed at length.

The AMA's Medigredit bill was discussed—helps individuals with catastrophic illnesses. The Board went on record as favoring this bill.

The Board rejected participating in the Quality Assurance Program being planned by the Indiana Hospital Association.

Chairman of the ISMA Commission of Public Information gave a report on the speakers bureau. The Board unanimously was in favor of this program and felt that in time this would be an excellent way for ISMA to tell the true story of medicine.

Indiana University Medical School Department heads, the I.U. Medical School Alumni, and members of the ISMA Board met with the Dean of the I.U. School of Medicine. The department heads gave a very comprehensive report on the policies and functions of the I.U. Medical School.

Chairman of the ISMA Medical Economics and Insurance gave a report on the coordination of benefits in health insurance policies. The Board moved that the Commission investigate the cost of malpractice insurance policies and continue to study this problem.

The Board moved not to introduce a free standing physician assistant bill.

The Third District Trustee gave a report of his personal survey in his district on PSRO. Seventy-two of his colleagues returned his questionnaire—29 agreed with the AMA House Action on PSRO, 30 opposed.

#### FEBRUARY 11, 1973, MEETING

The Board unanimously voted to give President Gosman the authority to proceed with a class action suit against PSRO law and Phase III regulations. The Board further went on record as opposing the principles of PSRO.

Dr. Alcorn gave a report on the status of the Medical Practice Act.

Wayne Stanton, new director of the State Department of Public Welfare, re-

ported to the Board that his department was compelled by a federal mandate to consider the screening of all young people and children 21 years of age and younger under the Medicaid program. He stated that retaining federal funds for state welfare was at stake. His plan was not to engulf the medical profession in Indiana with the project, but he was desirous of screening as many of these children and young adults as possible through the surveys of parents, teachers, and other individuals.

James Herod, president of Blue Cross, reported to the Board on the health care crisis in the United States. He said that he felt this was the time for Blue Cross-Blue Shield, ISMA, Indiana Hospital Association, and other health care groups to work together in the action program for the betterment of health care for Hoosiers. Mr. Herod (to carry out this action program) listed 12 objectives, which the Board endorsed.

#### APRIL 14-15, 1973, MEETING

The Board had a long and thorough discussion of the Professional Standards Review Organizing Law, and it reiterated its previous action of going on record as opposing the PSRO and to continue to fight the concept.

Dr. William Paynter, the new Indiana State Health Commissioner, stated that the health activity in the federal system is undergoing a major reorganization. The Board was impressed with Dr. Paynter's comments.

David Johnson, executive director of Deaconess Hospital, Evansville, gave a report on the use of computers in the practice of medicine. Also, Mr. Johnson gave a report in which the "Washington Post" cited corruption in hospitals throughout the nation.

Dr. Robert Reid gave a report on Medi-Tech—another computerized system.

Roger Zion, congressman from the Eighth Congressional District, gave a report of the health bills in the present Congress. He was asked about class action suits against any of the laws that have been passed. In his opinion, this type of action should be the last resort.

H.M.O.s received considerable discussion by Board and the Board disapproved this type of organization for delivery of medical care. The Blue Shield representative queried the Board concerning the advisability of their acting as Fiscal Intermediaries for such plans in Indiana, and the Board moved that, when a specific proposal was received by



Blue Shield for acting in this capacity with HMO, they return to the ISMA with the request, and that in the meantime the Board go on record as being unalterably opposed to the HMO concept.

Mike McDermott, legislative assistant of ISMA, reported to the Board regarding the 104 bills dealing with subjects related to the medical profession. Forty of these bills failed, while 26 will be signed by the Governor. Fifteen bills were strongly supported by the ISMA, of which 7 will become law, and 8 failed. The Board applauded Mr. McDermott for his work with the Legislature.

The Board gave the "green light" for the chairman of the ISMA Medical Economics & Insurance Commission to continue discussion in regard to the Florida Medical Association Plan for handling malpractice insurance.

A request for contributions to the Eisenhower Memorial Scholarship Fund was rejected by the Board.

The Board was pleased with their Tel-Med Program which was installed earlier this year. They have been receiving (on an average) approximately 800 calls a day.

Dr. Grosz gave a report on the effectiveness of the drug Propranolol in blocking heroin effects. The Board moved that it assist Dr. Grosz in his work. It was gratifying (at a following meeting) to see the effectiveness of the State Organization action, since by our assistance he was able to gain a grant from the federal government.

Chairman of the ISMA Commission of Emergency Medical Services gave a report on emergency care. The Board approved the Commission's plans.

#### MAY 20, 1973, MEETING

The Board approved the report that the Building Committee should explore the expansion or move of the ISMA building, since the present facilities are overflowing its present capacity.

The at-large members representing ISMA on the Blue Shield Board met with the ISMA Board of Trustees to discuss current plans to expand Blue Shield Board. Everyone thought the discussion was good—ideas and thoughts were received in both directions.

The Board moved that the House of Delegates, in our October meeting, make the decision whether state medicine become involved with PSRO concept.

#### JUNE 17, 1973, MEETING

The AMA delegates and alternate delegates gave a thorough and excellent re-

port on the matters being referred to the Reference Committees at the AMA meetings in New York.

#### JULY 15, 1973, MEETING

This meeting was set aside to discuss PSRO and what presentation we should make before HEW on July 24, 1973. In the discussion it was noted that the Board was on record as favoring the House of Delegates, at our annual convention in October, to decide whether we govern PSRO. In order that all avenues of discussion at our annual convention will be given, the Board voted, at this time, to present a state-wide "umbrella" PSRO in their presentation before HEW.

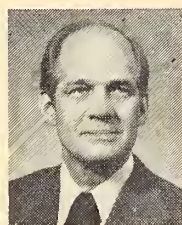
A discussion on continuing education, in regard to recertification and relicensure, followed. This discussion centered around keeping the Trustees informed on this topic which has been brought to the forefront at the AMA level.

#### IN SUMMARY

The Board planned and participated in many programs that are not mentioned in the preceding report; for instance, the Washington Legislation Visitation, the Student-Faculty-ISMA member meeting at Nashville, our Treasurer's financial report, etc. A more complete report can be obtained in the editions of the *Indiana State Medical Association Journal*.

GILBERT M. WILHELMUS, M.D.  
Chairman

#### First Trustee District



GILBERT M. WILHELMUS, M.D.  
Trustee

The annual meeting of the First District Medical Society was held on May 24, 1973, at the Rolling Hills Country Club, Evansville.

The meeting was well attended, with over 170 members and their wives. Mead Johnson was the host for our social hour preceding the dinner. It was noted at the meeting that Mr. O. Miller, physician representative from Mead Johnson, was retiring this year. All the physicians in the First District wished Mr. Miller many years of retirement enjoyment.

Otis Bowen, M.D., the Honorable Governor of the State of Indiana, was

our speaker. All the physicians and their wives were pleased to visit and talk with Governor Bowen—he is held in high esteem in our area as well as over the entire state. Dr. James Gosman, ISMA President, was present and gave a comprehensive report on our business at the state and national level. Dr. Gilbert M. Wilhelmus, Chairman of the Board of Trustees of the ISMA, gave a report on the activities occurring at the state level, and especially a report on PSRO. He urged the members to become well informed in regard to the PSRO concept in order to let their representatives know what action to follow at our state convention. Mr. James Waggener, Executive Secretary of ISMA; Mr. Robert Amick, District Representative; and Mr. Mike McDermott, Legislative Assistant of the ISMA—were in attendance. Mr. McDermott gave a summary of the bills introduced into the state legislature—and in particular of the 104 bills which had some bearing on the physicians in our state. Dr. Willard T. Barnhart, First District Representative on the Blue Shield Board of Directors, gave a report on the activities of Blue Shield. He stated that the Administrative consolidation of Blue Cross-Blue Shield has been working very well. He further stated that, should this arrangement become unworkable in the future, it can be terminated by either party at any time. Mr. Herbert Dixon, vice-president of Professional Relations of Blue Shield, was in the audience and was available to answer any questions regarding Blue Shield matters.

After the meeting the following officers were elected:

William Dye, M.D., President

Albert Ritz, M.D., Vice-President

John M. Bender, M.D., Secretary-Treasurer

Ralph Carlson, M.D., Representative to Indiana Blue Shield

Bernard Rosenblatt, M.D., Alternate Trustee

Postgraduate medical education is still one of our primary interests in the First District. Dr. Corcoran, head of the I. U. Medical School Extension Program in Evansville, is developing excellent medical facilities for teaching medical students. As a result, there has been an increase in the number of medical students desiring to obtain their medical education in our locale. Since postgraduate education is in the forefront, the number of interns and residents is increasing yearly.

Some of the highlights in the past year which have occurred in the First District



(especially in Vanderburgh County) are: 1. Organization and implementation of the Peer Review Committee. 2. The Answering Service Feasibility Study carried out by the Emergency Service and Indigent Care Committee. 3. The organization of the Medical Review Committee. 4. The acquisition of many new physicians. 5. An orientation meeting for newer members to instruct and show them how the AMA, ISMA, and County Medical Society can help them and how they can help these organizations. 6. The creation of the Ad Hoc Committee to investigate a medical guild.

As a member of the Board of Trustees of the Indiana State Medical Association, it is rewarding to see the number of physicians working together helping organized medicine to be the leader in the health care field. Moreover, it is obvious that the great majority of physicians in the state of Indiana do not want third party involvement. The trustee wants to thank the many members of the District for their cooperation and activity in their local medical society and in participating on the commissions and committees of the ISMA.

The District appreciates the efforts of Mr. Robert Amick for his attendance and suggestions throughout the entire District.

The trustee is grateful for the cooperation and opportunity to serve his fellow physicians in the First District.

GILBERT M. WILHELMUS, M.D.,  
*Trustee*

## Second Trustee District



PAUL W. HOLTZMAN,  
M.D.  
*Trustee*

The Second Medical District met May 17, 1973, at the Fourwinds Inn on Lake Monroe with Dr. Robert Robinson presiding. It was decided that the next meeting would be at Sullivan.

The afternoon session was a two-hour discussion chaired by Dr. Paul Holtzman, on HMO, PSRO, and other current medical events. The meeting was poorly attended.

In the evening, the Honorable Lee Hamilton, Congressman from Indiana, spoke regarding the present and future of American medicine. This meeting was also poorly attended.

During this year, I have made every effort to bring the Indiana State Medical Association to the doctors in this district, and made every effort to acquaint the physicians with the benefits therefrom derived.

There is general apathy, distrust, and misunderstanding regarding the role of the Indiana State Medical Association and its relationship to the practicing physician. There is little interest in what has been or what can be accomplished by the association.

Certainly, in my opinion, something must be done to properly inform and organize men in the district as, at present, they are all floundering in disarray awaiting the inevitable and seemingly reluctant to speak their piece or participate in any concerted action toward preventing government interference in medicine. Hindsight abounds—foresight is ignored.

We have a continuing responsibility and opportunity to educate regarding American medicine but we **must** start with the doctor.

PAUL W. HOLTZMAN, M.D.  
*Trustee*

## Third Trustee District



ELI GOODMAN, M.D.  
*Trustee*

At the 1972 meeting of the Third District held in May at New Albany, it was agreed to hold the 1973 meeting in September.

Accordingly, the 1973 meeting is scheduled for Wednesday September 26, with the meeting to begin at 4:00 p.m. at the Marriott Inn at Clarksville, and with golf available at the Valley View Golf Course at New Albany.

The after-dinner speaker will be Dr. Richard C. Bates, the Lansing, Mich., internist who is noted as a humorist. State officers will be present to discuss PSRO pending legislation and other items of current interest to the medical profession.

Claude J. Meyer, M.D., will preside as district chairman, assisted by Robert McKechnie, M.D., district secretary. A district trustee is scheduled to be elected during the business meeting.

During the past fiscal year there were some intramural problems in Lawrence and Orange counties, all of which were

probably based on faulty communications. State Association President James Gosman has visited both counties and used his good offices to bring about satisfactory resolutions. I am continuing, in my position as Trustee, to try to amicably adjudicate a remaining problem involving ethical intra-relationship.

In another situation, I have made an ongoing effort to assist one physician who had begun to be criticized for an apparent decrease in his efficiency which, I am satisfied, if it existed, was brought about by many hours of overwork in an area very short of physicians.

Probably the most serious single issue to confront the district membership this year has been the national problem of decision making brought about by the passage of the law providing for Professional Standards Review Organization. (PSRO).

I personally consider that the impact of PSRO, when it has been fully implemented, will entirely change the nature of the medical care of the American people (unfavorably) and, of course, the effectiveness and life-position of each and every physician along with it.

Therefore, I polled the membership of the Third District by certified mail (at my own expense). About one fifth (1/5) of the members replied. About two out of three replies were opposed to PSRO. As a result, I have considered myself to be mandated to oppose PSRO at all levels. This I have done in visits to component county societies, and by motion and vote in all meetings of the Board of Trustees.

I was also the only physician from the state of Indiana to give public testimony in opposition to PSRO before the Reference Committee at the June 1973 meeting of the American Medical Association in New York.

At the annual meeting of the Indiana State Medical Association this October, a resolution will be presented from Clark County, which is one of my constituent counties and is my home county, that will oppose PSRO.

I urge all delegates from the Third District (and indeed all districts of ISMA) to carefully study all the issues involved in PSRO.

Decisions made by the House of Delegates this October, will probably be the most important that organized medicine have ever been called on to consider.

ELI GOODMAN, M.D.  
*Trustee*



Fourth Trustee District



HOWARD JACKSON,  
M.D.  
Trustee

The 1973 meeting of the Fourth Medical District was held in Columbus, on May 9, 1973. Presiding was Dr. Kenneth Schneider. The meeting was well attended. Members of the District were particularly pleased that the President was present for the meeting. Many members of the ISMA staff were present, for which we are appreciative.

Elections were held, and Dr. Jack Shields was elected president, Dr. William Warn was elected vice president, and Dr. John Ripley was elected secretary-treasurer. Dr. William Blaisdell was re-elected alternate trustee. Mr. Tommy Mont, head football coach and athletic director at DePauw University, was the speaker at the evening meeting. His humorous talk was enjoyed by all. Next year's meeting will be hosted by the Jackson-Jennings County Medical Society in Seymour. The date has not been determined.

The traveling golf trophy was retired by Dr. Richard O'Bryan. There was a tie for second low gross between Drs. Shaffer Berkshire, Donald Moore, and Kenneth Schneider.

As your Trustee, I visited several of the County Society meetings. The discussions and exchange of ideas at these meetings were a great help to me in representing you at the Board of Trustees meetings. I would like to be able to visit each County Medical Society meeting at least once each year. I think it is vitally important for the Trustee to be cognizant of the thinking of the physicians in his district.

HOWARD JACKSON, M.D.,  
Trustee

Fifth Trustee District



CLEON M.  
SCHAUWECKER, M.D.  
Trustee

The annual meeting of the Fifth Dis-

trict Medical Society was held on May 23, 1973, at the Windy Hills Country Club at Greencastle. The business meeting was called to order at 4:00 p.m. by James C. Lett, M.D. Approximately 40 members were present.

The district was pleased to have Gilbert M. Wilhelmus, M.D., chairman of the Board of Trustees, as a guest. He spoke on ways of strengthening the district societies and also on the present status of PSRO. This projected a lively discussion and it was the unanimous opinion of all present that PSRO is a very poorly written piece of legislation and probably not workable; however, it was pointed out that the only way it might possibly work would be for physicians to be in charge. A resolution was passed that the Fifth District go on record as being in opposition to PSRO.

A movie produced by the AMA was then shown concerning some of the problems confronting the medical profession and for the necessity of all doctors to work together in an effort at finding solutions.

Mr. Mike McDermott then gave a summary of the legislation passed during the last session of the legislature. Mr. Herb Dixon of Blue Shield then spoke and informed the group that Blue Shield would not, under any circumstances, act as a PSRO agent or become involved.

The election of new officers was then held and the following were elected:

- Alternate Trustee—William G. Bannon, M.D. (Terre Haute)
- Blue Shield Representative—Fred Dierdorf, M.D. (Terre Haute)
- President, Fifth District (1973-1974)—J. Franklin Swaim (Rockville)
- Secretary-Treasurer, Fifth District (1973-1974): Antolin M. Montecillo, M.D. (Clinton)

The final business item was the proposal to obtain a secretary for the entire Fifth District. This proposal will be studied by a committee composed of the presidents of each county society in the district, plus the newly elected president, Franklin Swaim. They shall report to our respective county societies no later than September 1973.

Following the business meeting, dinner was served to approximately 75 members. The featured speaker of the evening was Charles C. Hite who spoke on "Humor—Not Aspirin." The talk was very well received.

It was the opinion of those present that this was the best planned Fifth District meeting in many years. A great debt is

owed not only to the present officers but also to the staff of the State Medical Association for its assistance.

CLEON M. SCHAUWECKER, M.D.  
Trustee

Sixth Trustee District



PAUL M. INLOW, M.D.,  
Trustee

I wish to take this opportunity to acknowledge the support that Dr. Glen Ward Lee, alternate trustee from the Sixth District, has given me by his tremendous attendance record at the trustee meetings this past year.

This has been an exciting year at the state level with Dr. James Gosman at the helm. We have seen the launching of Tel-Med in Marion County and the beginning of a speakers' bureau to tell the physicians' story, which was initiated by the Commission on Public Information. These are both great public relations ideas.

The Sixth District Meeting was held at the Durbin Hotel at Rushville May 2, 1973. Dr. James Gosman, president of the Indiana State Medical Association, addressed the group. He explained the need to form a Professional Services Review Organization, at least on paper, at the state level. A show of hands indicated an overwhelming majority were in favor of proceeding along these lines.

The new officers of the Sixth District are: President—James H. Tower, Jr., M.D. of Shelbyville, Vice-President—Davis W. Ellis, Jr., M.D. of Rushville and Secretary-Treasurer—Arlington M. Hudson, M.D. of Connersville.

The after-dinner speaker, Rev. Phillip Philbrook, a Baptist Minister from Ft. Wayne, was introduced by Past-President John Moenning. Rev. Philbrook's speech was entitled "The Three Bones." The presentation was interspersed with humorous stories and gave criteria for a successful life. The Funny bone symbolizes a need for a sense of humor, the Wish bone a desire for life goals and the Back bone the perseverance to accomplish these goals.

P. M. INLOW, M.D.,  
Trustee



## Seventh Trustee District



JOHN O. BUTLER, M.D.,  
Trustee



JOSEPH F. FERRARA, M.D.  
Trustee

Dr. Ray D. Miller of Martinsville was elected president-elect of the Seventh District Medical Society at the organization's annual meeting held June 20, 1973, at the Speedway Motel in Indianapolis. He will succeed Dr. Eric D. Clark, of Plainfield.

Dr. Malcolm O. Scamahorn of Pittsboro was reelected Secretary-Treasurer.

The meeting was held following an afternoon of golf and a demonstration of handwriting analysis for the members' ladies.

Dr. Donald E. Stephens of Indianapolis, president, called the meeting to order after members had viewed a motion picture on American Medical Association membership and activities. He then introduced Michael H. McDermott, legislative assistant, Indiana State Medical Association, who reviewed actions of the 1973 Indiana General Assembly pertaining to medicine.

Dr. James H. Gosman of Indianapolis, president of the state association, then discussed that body's actions and positions in regard to the American Hospital Association's Quality Control Program, Professional Standards Review Organizations, malpractice insurance and state headquarters space limitations.

Dr. Gosman moved, seconded by Dr. Ted L. Grisell, of Indianapolis, that the district society oppose any hospital direction which would establish limitations of medical practice and that the society insist that hospital privileges be kept under the control of medical staffs. The motion was carried.

Following an address by the Rev. Philip C. Philbrook of Fort Wayne, the meeting was adjourned.

Time and place of the 1974 annual meeting has not yet been determined.

JOHN O. BUTLER, M.D.  
Trustee  
JOSEPH F. FERRARA, M.D.  
Trustee

## Eighth Trustee District



RICHARD INGRAM, M.D.  
Trustee

When this report is published, the 1973 Eighth District Medical Society Meeting will be history. This meeting, we hope, will usher in a new era of activity at the District level in the sense that a much larger percentage of members will have been present to carry out the business of the District. Any such increase in attendance will be due to the direct efforts of the District Society President Dr. David Dietz, and the fine evening program he has arranged.

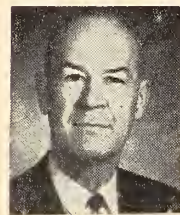
It does seem important to me that more members are active in the medical political activities of our Medical Societies at all levels, since we are now in a time when changes are being politically wrought in the practice of medicine which may actually alter the quality and availability of care for our patients forever. In this area, there are two general approaches to the problems of governmental interference in the practice of medicine, plus a third totally unacceptable approach. To dispense with the third approach first: It is the idea that nothing can be done, and all efforts are useless. This is a hopeless attitude and, therefore, unacceptable in my opinion.

Another frequently suggested approach to the problems concerning governmental interference in our practice of medicine is that we, ourselves, try to run and apply the proposed government programs, thereby somehow making them less punitive, and less likely to alter the patterns of care that we are used to. However, from experience we might well learn that in the past, when we have chosen to, in a sense, play ball with Government programs, we have continually been the loser, and great inroads have been made into the private nature of the contract between us and our patients. Therefore, in my opinion again, this approach is no longer feasible. The final approach, and the one most important in my opinion, is that we finally decide, as physicians, we do have a responsibility for the care of our patients, and a responsibility to keep that care private, to tell the Government that we no longer will participate in programs of control over the private contracts that take place between the doctor and the

patient. I recognize that this is a difficult task to undertake. It takes a degree of unanimity that we have never had. But if ever the physicians are going to be able to unite in a solid front to preserve the practice of medicine, in the way we believe best to give quality care to our patients, now is the time to do it. I would urge, therefore, that physicians the state over think seriously about the problems that are coming up concerning governmental intervention in our practices. And if you think that this problem has reached such proportions that it is no longer possible to brook any interference in our practice by the government, then we should unite and do our best to practice medicine in the private fashion that we were used to doing, and refuse to participate in control schemes that are furthered by the politicians.

RICHARD INGRAM, M.D.  
Trustee

## Ninth Trustee District



WILLIAM M. SHOLTY,  
M.D.  
Trustee

The Ninth District meeting was hosted by the Fountain-Warren Co. Medical Society on June 14, 1973, at the Attica Hotel, Attica. The president Dr. Lowell Stephens, presided. Mr. James McNamara, an attorney from the AMA, gave the pros and cons of medical corporations and Keogh plans (HR 10).

Benton, Boone, Clinton, Fountain-Warren, Hamilton, Montgomery, Newton, and Tippecanoe Counties were represented. Tipton, Jasper, and White Counties did not have delegates present.

ISMA president, Dr. James Gosman, presented the plans for the convention to be held October 8, 9, 10, 11 in Indianapolis.

Mr. James Waggener, ISMA executive secretary; Herb Dixon, executive vice-president of Blue Shield; Dr. Thomas Tyrrell and Dr. K. O. Neumann, alternate AMA delegates; Dr. William Sholty, Ninth District Trustee; and Dr. Barton Bridge, Ninth District Blue Shield Representative were introduced.

Dr. Barton Bridge reported on the changes and progress taking place. Efforts to pay for more office procedures



are being made. Many claims declared questionable in the past will be covered.

During the business portion of the meeting, Dr. William M. Sholty was nominated and elected Ninth District Trustee for a second term.

Drs. Peter Petrich and Barton Bridge were nominated for Ninth District Blue Shield Representative. Dr. Petrich was elected.

Socializing pressures seem to be always present from all directions. Rest assured that your ISMA is doing all it can to preserve the freedom of medical practice as it has been known in the past.

Next year's meeting will be hosted by Clinton County.

WILLIAM M. SHOLTY, M.D.,  
*Trustee*

Tenth Trustee District



VINCENT J. SANTARE,  
M.D.,  
*Trustee*

The Tenth District Meeting was in May 1972, at which time Dr. Dimitroff was re-elected president of the Tenth District; Dr. Mansueto was elected secretary; Dr. Martin O'Neill was elected alternate trustee; and Dr. William Fitzpatrick was elected Blue Shield Board Representative.

The meeting this year is to be held in September 1973, at the Lake of the Four Seasons. There are no elections to be held this year. Both Lake and Porter Counties have a good representation in the Calumet Foundation for medical care, the President of which is Dr. Lee Trachtenberg. The Foundation has been established in order to qualify as a PSRO organization, when the time and circumstances are feasible.

Dr. Ramker continues as president of Lake County Medical Society, finishing his second year. Porter County is being served by Dr. McBride as president of the County Medical Society, and Dr. A. Kobak has been selected as president-elect, to serve as president in the year 1974.

VINCENT J. SANTARE, M.D.,  
*Trustee*

Eleventh Trustee District



JAMES A. HARSHMAN,  
M.D., *Trustee*

The problems facing the district are the same that we have been facing for a number of years. By far the most serious problem is that of a lack of primary care physicians. Whether it is an actual shortage or merely a maldistribution of physicians, the end result is the same. In a study completed a couple of years ago by the ISMA headquarters staff, the ratio of population to family practitioners was listed for each county of the state. In the 11th district the following ratios were found: Cass County, 3,517:1, Carroll County 1,901:1, Grant County 3,736:1, Howard County 4,741:1, Huntington County 3,227:1, Miami County 3,927:1, and Wabash County 1,972:1. For the entire district the ratio of population to family practitioner was 3,364:1. These ratios all exceed those for the national average.

Not much has happened in the past two years to change the picture. The family practice programs in the state are slow in getting started, and the demand far exceeds the supply. The problem is further compounded by the superspecialization that is occurring in the fields of internal medicine and pediatrics. No longer are general internists and pediatricians being trained, but rather hematologists, endocrinologists, oncologists, nephrologists, gastroenterologists, rheumatologists, cardiologists, etc. When an internist or pediatrician subspecializes, he is automatically committed to practice in a community of at least 100,000. Only a few communities in the state have this dense a population; thus leaving numerous smaller communities without internists and pediatricians. By necessity, the family practice programs are going to have to fill this void. Perhaps this is because the family practice department, which is in its infancy, is having too much competition from the established dynasties of the university for the appropriation dollar. Educators are going to have to face this problem more squarely than they have in the past, or they are likely to get "assistance" from persons outside the academic and medical communities.

There is growing concern among the

physicians of the district about the increasing governmental intervention and interference into the private practice of medicine. One of the most profound of these governmental programs is to be found in P.L. 92-603, the PSRO. There is almost unanimous opposition to PSRO in the district. Now that it is law, the question really centers around what we are going to do about it. Our course of action will be determined by the House of Delegates. Our options are somewhat limited, but the decision as to what course to take may be one of the biggest decisions organized medicine will have to make for a few years to come. I am a firm believer in the institution of the House of Delegates, and I believe that this decision should be made by those representing the "grass roots" of the medical community.

Another serious problem confronting the entire state is that of drug abuse. Practically everyone shares some responsibility in this problem, including the medical profession, law enforcement, parents, industry, schools, etc. Since the total community is involved and responsible, it will require total involvement of the community to find solutions. This includes the medical profession. The number of persons that abuse drugs is astronomical. There are increasing numbers of younger school children that are experimenting with drugs. Realism may be the first step toward solving the drug abuse problem instead of trying to scare it to death. The total community must join in this realism.

Publicity about drug abuse seems to have peaked, but the problem of drug abuse with all its ramifications has not yet begun to peak. Several years ago drug abuse was blamed on overprescribing physicians, or permissive parents whose medicine cabinets were filled with "appetite" pills and tranquilizers, on generation gaps, and on a sick society. Today we are less inclined to oversimplify the drug abuse problem. It is clearly more than a medically created problem. I know of no other profession aside from the medical profession whose input could be greater in helping a community find solutions to the drug abuse problem. In my own community of Kokomo, school administrators, law enforcement, industry and city officials have all asked for assistance from the medical profession. Although drug abuse is only one of several serious problems facing our society, it is clearly one which the medical profession can lend its expertise to.

Last September the 11th District Med-



ical Society was hosted by the Howard County Medical Society in Kokomo at the Stellite Park. After an afternoon of golf, the members discussed legislative matters with Congressman Elwood H. Hillis. At the business meeting the following officers were elected: President: Joseph Bean, M.D., secretary-treasurer: Fred Poehler, M.D., ISMA trustee: James Harshman, M.D., ISMA alternate trustee: Lloyd Hill, M.D. (filling an unexpired term ending in 1974).

Grant County Medical Society will host the 1973 district meeting.

**JAMES A. HARSHMAN, M.D.**  
*Trustee*

## Twelfth Trustee District



**Wm. R. CLARK, SR.,  
M.D.**  
*Trustee*

This is my last report to the ISMA and my 12th District. I have seen many changes in organized medicine in the five years that I was an Alternate Trustee and the past six years as a Trustee. The changes during this time have been tremendous. I can well remember when being on the Board was more or less a simple challenge compared to the problems of Medicare, Medicaid and health care as now presented.

To the constituents of ISMA, may I say these have been not only trying but revolutionary to what it was ten years, even six months ago. I have been accused of preaching in my own District—saying over and over that there was too much apathy on the part of the rank and file of all physicians. I am only sorry that every physician of the ISMA could not sit month after month with the Trustee Board in order to realize the great problems that are facing the physicians of our country.

May I say to you that the Commissions, Committees, Alternate Trustees, Trustees, Executive Committee, the State Officers, and your President are doing a yeoman job. It is unbelievable the number of hours they have given without remuneration or acclaim in behalf of the membership. I want to especially commend Mr. James Waggener and his staff. You will never know how dedicated Jim and his people are until you have had the privilege of observing their great efforts in our behalf.

I sincerely believe that the majority of the membership is not in favor of or happy with PSRO, HMO, and HEW. As a Trustee, I have not supported any of these above programs as I felt that it was not only an indictment but class legislation against the physicians of the United States. Why Congress does not select other professions or castes for its reprimanding, I am unable to understand. However, now that it is a law, I feel that the AMA, state and county officers should set up the guidelines as to how it is to be implemented, thereby not completely losing control of our own destiny.

I have had the privilege of visiting many foreign countries and, without reservation, I state that our health care, the capability of our physicians and the patient-physician relationship is the best in the world. Let us try hard to keep it that way. The prospect of what will happen to the practice of medicine is still in the ova state and not determined. However, I want you to know that I sincerely believe it is in the good hands of your state, district and county officers.

May I add that it has been great privilege to have worked with some of the finest men I have ever known. I don't know who will be my replacement, as this article is being written prior to our annual district meeting but may I wish my successor great wisdom in his representation of the 12th District.

Last and above all may I thank the District for the great honor and trust they bestowed on me in representing them the past years.

With best wishes for the 12th District and the ISMA.

**WILLIAM R. CLARK, SR., M.D.**  
*Trustee*

## Thirteenth Trustee District



**G. BEACH GATTMAN,  
M.D.**  
*Trustee*

The Thirteenth District Medical Society held its Annual Meeting in Michigan City, September 13, 1972. Due to inclement weather, the golf tournament was canceled. There was a moderate attendance at the business meeting where the report of the Trustee was given. In other business, Dr. James Rimel, Plymouth, was elected President, Dr. Jack Hannah, Elkhart, president-elect, and

Dr. David Spalding, Mishawaka, re-elected secretary-treasurer. Dr. Francis Kubik, Michigan City, was elected to the Blue Shield Board to replace Dr. Edward Dovey of Elkhart.

Dr. Peter Petrich, president of the ISMA, Dr. James Gosman, president-elect ISMA, and Mr. James Waggener, ISMA Executive Secretary, were in attendance at our meeting.

The afternoon business session was concluded with a discussion of the proposed Medical Practice Act by Dr. Franklin Bryan and Dr. Merritt O. Alcorn. A question-and-answer period followed.

The evening program following dinner was presented by the "Green Mountain Boys," M.D.s from Springfield, Missouri, who entertained us musically with originality and humor. A special plaque was given to Dr. Otis Bowen for his service to the 13th District.

Due to the illness of Dr. Frank McGue of Michigan City, president of the 13th District, president-elect Frank Rimel presided.

Our District has been active in formulating plans for District meetings which are to be held three to four times a year in conjunction with a regular meeting of one of the Counties in our District. It is hoped that the County officers and delegates will be able to attend these meetings along with other interested members of the District. The first of these was held by the St. Joseph County Medical Society in May 1973. Topics for discussion will no doubt include PSRO, HMO, and other subjects of interest to the membership.

The next meeting of the District will be November 12, 1973 in Plymouth, Indiana.

**G. BEACH GATTMAN, M.D.,**  
*Trustee*

## Editor of The Journal

*The Journal* is operating within its budget this year. Due to the fact that revenue from national advertising accounts has been less than that for the same period last year by 35% it has been necessary to have smaller issues for most of the months since last report. Local advertising has been at a normal level.

The interest income of the Indiana Medical Foundation, Inc., has been allocated to *The Journal* and each year is utilized for artwork. As the Foundation grows, this financial aid will increase and provide improvements in publication.



In addition to an especially fine contribution of clinical articles, special papers on treatment of drug addiction, cancer chemotherapy, informed consent and the training of physicians' assistants have been featured.

The history of medicine in Indiana has been covered by tributes to Dr. Frank B. Wynn, the father of the medical scientific exhibit, and to Dr. Alfred Ralph, a dedicated pioneer physician.

The one special issue of the year was devoted to the Methodist Hospital of Indianapolis and its graduate education program.

Another special feature was the publication of a report by John C. Johnson, a student at Indiana University School of Medicine, who conducted a unique and helpful study of physician needs in the state.

*The Journal* enters another year of publication with an ample supply of scientific material.

FRANK B. RAMSEY, M.D.  
*Editor*

## Delegates to AMA

RUSSELL B. ROTH, M.D., BECAME AMA'S 128TH PRESIDENT during the annual convention in New York City, June 24 through 28. The Erie, Pa., physician has served for 20 years in various capacities with his county and state medical societies and with the AMA.

MALCOLM C. TODD, M.D., LONG BEACH, CALIFORNIA AND MEMBER OF THE CALIFORNIA DELEGATION was elected to the office of president-elect. E. Bryce Robinson, Jr., M.D., Birmingham, Alabama, was elected vice-president.

EUGENE E. SENSENY, M.D., FORT WAYNE, was chosen LEADER FOR INDIANA DELEGATION, was unable to attend the session because of emergency surgery. James A. Harshman, M.D., Kokomo, was elected by the Indiana delegate body to handle the floor leader's responsibilities.

STATE DELEGATIONS CONSIDERED MORE THAN 164 RESOLUTIONS and a volume of reports from the AMA Board of Trustees and the Councils and Committees of the AMA.

PSRO REPORTS AND RESOLUTIONS RECEIVED CLOSE ATTENTION AND DELIBERATION but the broad variety of matters facing the delegate body included such topics as Phase III Fee and Wage Controls, patient's

right to die in dignity, AMA membership in the World Medical Association, abortion, Medigap, intern and resident delegate representation, drug abuse, sale of contraceptives, paramedical personnel, occupational safety, HMOs, Food and Drug Administration and intrusion in the practice of medicine.

WORKING LONG AND HARD TO COVER THE AREAS PRESENTED, the ISMA delegation caucused continuously to review reports and plan their actions in the House.

PRESENT FOR THE MEETING FROM THE DELEGATION BESIDES CHAIRMAN PRO-TEM HARSHMAN were Jack E. Shields, M.D., Brownstown; Lowell H. Steen, M.D., Hammond; Malcolm O. Scamahorn, M.D., Pittsboro. Alternates attending included Patrick J. V. Corcoran, M.D., Evansville; Thomas C. Tyrrell, M.D., Hammond; Ross L. Egger, M.D., Daleville, and Kenneth O. Neumann, M.D., Lafayette. Joining the delegation in their deliberations were Sprague H. Gardiner, M.D., Indianapolis, Section on Obstetrics and Gynecology; Lall G. Montgomery, M.D., Muncie, Section on Pathology and Myron H. Nourse, M.D., Section on Urology. President of ISMA, James H. Gosman, M.D.; President-Elect Joe Dukes, M.D.; Chairman of the Board Gilbert M. Wilhelmus, M.D., and Immediate Past President, Peter R. Petrich, also participated.

TEN REPORTS AND RESOLUTIONS ON PSRO CAME BEFORE THE HOUSE, among which were Resolutions 49, 107 and 150. Resolution 49 called on the Association to publicize the deleterious effect PL 92-603 could have on quality of care and to assign "highest priority" to developing and pursuing appropriate amendments to PL 92-603; Resolution 107 asked AMA to go on record as opposed to PSRO; and Resolution 150 asked for repeal. During the hearings, these resolutions called forth considerable emotional support from physicians attending, and strong criticism of the PSRO approach to review. The House adopted the following substitute resolution in lieu of the three.

"Resolved, That although it is recognized that repeal or modification of PSRO legislation ultimately may be required to preserve high quality of patient care, the American Medical Association should oppose any facets of this current legislation which act to the deterioration of quality care, publicize such deleterious facets, and place highest priority on developing

and pursuing appropriate amendments to preserve high quality of patient care."

THE HOUSE ADOPTED A REPORT STATING THAT DUAL REPRESENTATION OF PHYSICIANS by unions and by their professional organizations would be divisive and counterproductive to the needs of the profession in dealing effectively with government and third parties. The report noted that, while physicians are entitled to join unions, they can best achieve the goals of the profession "through carefully planned action programs of the AMA and its constituent and component societies." The House urged the Board to continue its interest in employee physicians but said it is "convinced that the interests of the great majority of the members of the Association, who are self-employed practitioners in private practice, are not best served by the policies and practices of organized labor."

SEVERAL ACTIONS WERE TAKEN TO ENCOURAGE AND FACILITATE MEMBERSHIP IN THE AMA. They amended the bylaws to provide that (1) physicians become AMA members upon certification by the state society rather than upon receipt of dues by the AMA, (2) the AMA dues-delinquency date be changed from June 1 to April 30, (3) payment of one year's past dues for reinstatement of AMA members be eliminated, (4) the criteria for AMA dues exemption be consistent with that of state societies, (5) the AMA be permitted to bill directly for dues under certain circumstances.

FOOD AND DRUG ADMINISTRATION CAME UNDER STIFF CRITICISM through six resolutions. The resolutions asked the House to protest their regulatory activities. Among several resolutions adopted to change some of the FDA practices was the following:

"That the American Medical Association continue to protest those proposed and current regulatory activities of the Food and Drug Administration which have the effect of restricting the use of prescription drugs to approved labeling recommendations or which threaten to interfere with the exercise of a physician's professional prerogatives in selecting the drug of choice for a patient."

JACK E. SHIELDS, M.D.  
LOWELL H. STEEN, M.D.  
PATRICK J. V. CORCORAN, M.D.  
THOMAS C. TYRRELL, M.D.



# Reports of Committees

## Executive Committee

The Executive Committee met for organizational purposes immediately following the Board of Trustees' organizational meeting on October 18, 1972.

By secret ballot Donald M. Kerr, M.D. was re-elected chairman of the Executive Committee. Gilbert M. Wilhelmus, M.D., chairman of the Board of Trustees, Vincent J. Santare, M.D. and Arvine Popplewell, M.D., the new assistant treasurer, were welcomed to membership on the committee.

The signing of bank cards and other organizational matters of the committee were handled and the committee adjourned to meet again on November 18, 1972.

The Executive Committee convened at the headquarters building on November 18 and discussed the rendering of services to the IMPAC organization, discussed the problems the doctors were having with Aetna Insurance Company, approved the South Pacific tour for the members of the Association, reviewed the opinion of legal counsel concerning liability under the Tel-Med program, reviewed the AMA action on residents and interns, authorized representation of the Association at the AMA Leadership Conference, and reviewed the financial statements of the Association.

The Executive Committee was called to order by Dr. Kerr on December 17, at 9:30 a.m., with full attendance and Charles A. Bonsett, M.D., as a guest.

Dr. Bonsett appeared before the committee for the purpose of discussing the action of the House of Delegates concerning the conversion of the old Pathology Building at Central State into a medical museum. It was agreed the president would appoint a committee to meet with Dr. Bonsett and his committee to try to finalize some action on this project.

Reviewing the membership report, the committee decided to recommend to the trustees that they institute a membership drive in their respective districts to increase membership in both the ISMA and the AMA.

The committee authorized repairs to be made on the building for a leaky water line which was destroying the plaster in one of the offices.

They also reviewed the report of the

Medical Exhibitors Association concerning the reaction of the exhibitors at the 1972 meeting.

They also reviewed the report of the financial affairs of the Association, renewed membership in the Better Business Bureau and in WA-SAMA.

In addition to other housekeeping matters, they reviewed the matters of the Joint Medical Advisory Committee of the Blue Cross-Blue Shield, as well as matters of the Executive Committee of the Mutual Hospital Insurance.

They approved attendance at the 1973 Legal Symposium held at Las Vegas. Representing the Association were Drs. Wilhelmus, Dukes and Santare.

They approved representation of ISMA at the Medical Congress on Medical Education and approved the representative from the Commission on Special Activities to attend the Rural Health Conference, and set the date for the annual visitation of the congressional delegation.

The committee then adjourned as an Executive Committee and reconvened as a budget committee of the Association to review the proposed budget. The budget was approved upon motion by Dr. Hugh Thatcher, seconded by Dr. James Gosman.

The Executive Committee met at the headquarters building on January 20, 1973, and heard a report from the executive secretary that consideration should be given to future planning needs, inasmuch as all available space in the headquarters building is now occupied.

Dr. Gilbert Wilhelmus was appointed chairman of a travel committee for the Association.

They heard a report from the federal government congratulating the ISMA on its handling of the CHAMPUS program.

In addition to many housekeeping matters, the president was authorized to establish a membership committee to be chaired by Past President Dr. Peter R. Petrich.

The Executive Committee also took action to recommend several Indiana physicians for membership on the AMA councils and committees.

The committee turned down a request to co-sponsor an Institute on the Quality Assurance Program developed by the American Hospital Association.

The committee noted, in a report from the State Medical Journal Advertising Bureau, that Editor Frank Ramsey, M.D. of the Indiana Journal had been re-elected president of the board of directors.

Approval was granted for the Commission on Public Information to attend an annual Congress on the Socioeconomics of Health Care.

The chairman of the Commission on Aging was authorized to attend the meeting on The Role of the Medical Director in the Long-Term Care Facility.

The Executive Committee met on Saturday, February 17, at the Marriott Inn in Chicago. Guests at this time were Dr. Wood, AMA trustee, and Dr. Sprague Gardiner of Indianapolis.

The committee reviewed the Supreme Court decision on abortion and the committee decided the Association should take no part in sponsoring legislation on this subject. This was also reaffirmed by President Gosman's statement on abortion confirming the official policy of the AMA as being that of ISMA.

Plans for the County Society Officers' Conference for March 11 were reviewed and approved.

The secretary raised a question of certificate of need legislation and pointed out the deleterious effect upon physicians. He proposed some recommended changes in the bill, which were approved; and if the amendments were not successful, opposition to the measure would be expressed.

The secretary reported the CHAMPUS program for the year 1972 exceeded one-million dollars paid to the physicians of Indiana.

The secretary reported to the committee the discussion which he had with the secretary of the Florida Medical Society concerning their professional liability plan. By consent, it was agreed that the matter be referred to the Commission on Medical Economics and Insurance for further study and investigation.

The committee reviewed proposed changes in the constitution and bylaws of the Indiana Chapter of the American Association of Medical Assistants.

The committee replied to the request from the Department of HEW to submit names of three physicians from Indiana who are knowledgeable in utilization review, as possible members of the Regional Advisory Committee.

The secretary presented materials left in his office by a representative of the Social Security Administration with regard to the PSRO. Following a lengthy discussion of this matter and the implementation of Sections 207 and 237 of the law by the State Welfare Department, it was moved to refer this matter to the Future Planning Committee to draw up a plan on Foundations to present to the Board of Trustees for their review.



The Executive Committee convened at the headquarters office on Saturday, April 14, and heard a report from the executive secretary as to the four weeks of operation of Tel-Med, receiving 10,-196 calls.

The committee referred to the Board of Trustees a question of a policy on membership of public health physicians doing a tour of duty in the state of Indiana.

The secretary reported on two organizations coming into the state with mobile units and doing multiphasic screening of union groups. He pointed out that the question of legality had been referred to the Indiana State Board of Medical Registration and Examination and to the Indiana State Board of Health; but, according to their replies, there is apparently nothing that these two boards can do to stop this operation.

The committee heard a reply from the Deputy Attorney General concerning the right of the Board of Medical Registration and Examination to suspend a physician's license and this correspondence was referred to the Medical Disciplinary Committee of the Board of Trustees.

The committee authorized the filing of an amicus curiae brief for a lawsuit against a physician in Lake County.

The secretary read a letter from the attorney concerning a physician's responsibility in the Workman's Compensation Act and this was ordered to be reproduced in the News Flash.

A resolution for presentation to the AMA House of Delegates concerning a class action suit was referred to the Board of Trustees, as was a resolution proposed by the Commission on Special Activities.

The secretary announced that he had received a check from AMA-ERF in the amount of \$21,534.45.

A letter from the Indiana State Board of Health concerning new government regulations on amphetamine combinations and their recall was reviewed for the information of the committee and this is to be widely disseminated among members of the Association.

The attendance of S. O. Waife, M.D., as Indiana representative to the U. S. Pharmacopeial Convention was authorized.

The president was authorized to name a representative to attend the meeting of the Regional Home Health Conference.

The committee convened at the headquarters office at 2:00 p.m., Saturday, May 19 for transaction of its usual business.

Renewal of the lease on the rental property owned by the Association was approved.

Authorization was given to correct a leak in the foundation of the east wall of the building.

The treasurer reviewed his report of the investment of surplus funds in operations of the Association.

The committee approved an official statement from the Association on the viability of a fetus. This statement was requested by the State Board of Health.

The secretary reported on the activity of the Retail Credit Bureau in contracting its services with insurance carriers to obtain copies of patients' medical records from physicians in the state of Indiana. This matter was referred to the Board of Trustees for their information and action.

A report was received from the representative at the U.S.P. convention.

The committee advised the T. B. Respiratory Disease Association that it was felt their intended publication should not list the names of certain physicians as counsel to patients having this disease.

The result of the Physician-Faculty-Student Retreat in which the students recommended the establishment of an assessment committee to determine the community need for a physician was discussed, and Dr. Gosman was given permission to refer this matter to the Subcommittee on Rural Health (Commission on Special Activities).

They approved a request from the Commission on Public Information for a pamphlet on venereal disease to be distributed by Blue Cross-Blue Shield.

They approved the attendance of Dr. Gosman, Dr. Dukes, and the executive secretary at a special meeting called by the AMA.

They approved the guest list for the 1973 annual meeting and reviewed the outline of the program for the meeting.

Several matters dealing with Blue Cross-Blue Shield were also reviewed.

It might be pointed out that this is only a scanning review of the activities of the Executive Committee. The complete minutes for each of the meetings are in the hands of the Reference Committee for their review. The minutes have also been published regularly in THE JOURNAL for review by the general membership.

Medical Defense Activities

1. Malpractice Cases. A year ago at the time of this report, August 1, 1972, the following four cases were pending

before the committee:

Case 307 — Suit filed March 22, 1962. Pending. (Expense to date, \$1,042.73)

Case 313 — Suit filed September 5, 1967. Pending (Expense to date \$600.00)

Case 314 — Suit filed approximately July 6, 1970. Pending.

Case 316 — Suit filed July 2, 1970. Pending.

Since August 1, 1972 and to August 1, 1973, three new cases have been filed.

2. Medical Defense Fund Statement from August 1, 1971, to June 30, 1973; Bank Balance,

August 1, 1972 .....	\$16,963.11
Receipts .....	5,086.55
Total Cash and Receipts,	
June 30, 1973 .....	\$22,049.66
Disbursements .....	2,158.60
Balance on hand,	
June 30, 1973 .....	\$19,891.06

The Journal

Listed below is a comparative report of The Journal operations over the past several years and the first six months of 1973, as follows:

The first table shows the number of journal pages for the past six years (includes inserts).

Year	Reading	% Reading	Adv. Pages	% Adv. Pages	Total Pages	Av. No. Pages Per Issue
1967	1041	58	751	42	1792	149
1968	1068	61	696	39	1764	147
1969	1041	67	509	33	1550	129
1970	1131	74	403	26	1534	128
1971	970	70	426	30	1396	116
1972	933	69	433	31	1366	113

The table below shows the total printing costs of The Journal:

Year	Total Printing Costs	No. of Pages (Inserts Excluded)
1968	\$50,709.62	1462
1969	42,916.62	1312
1970	44,520.84	1346
1971	40,542.21	1232
1972	41,789.70	1106
1973 (6 mos.)	22,307.25	526

A comparison of advertising revenues for the first six months of the last four years, with a like figure for 1973, is as follows:



Year (Jan.-June)	Sold by State Medical Journal Adv. Bureau	Sold direct By Journal	Total
1969	\$17,086.59	\$2,557.80	\$19,644.39
1970	15,791.12	2,268.80	18,059.92
1971	13,128.30	1,821.89	14,950.19
1972	17,869.96	1,622.60	19,492.56
1973	10,938.94	2,134.95	13,073.89

### Membership Report

Total Members			
	December 1971	December 1972	
ISMA	4,554	4,587	
AMA	4,293	4,246	
	July 31, 1972	July 31, 1973	
ISMA	4,526	4,625	
AMA	4,179	4,292	

### DISTRICT REPORT AS OF JULY 31, 1973

District	+ Gain - Loss	AMA
	ISMA	
1	+12	+ 6
2	+14	+14
3	- 2	-
4	+ 4	+ 7
5	+ 8	+ 6
6	+ 4	+ 4
7	+16	+36
8	- 6	- 9
9	+18	+13
10	+ 1	+ 4
11	- 2	- 4
12	+15	+17
13	+17	+19
	+99	+113

### DEATHS

December 1972	52
As of July 31, 1973	22

### COUNTY/DISTRICT MEMBERSHIP REPORT

	Dec. 31, 1972 ISMA	July 31, 1972 ISMA	July 31, 1973 ISMA	July 31, 1973 AMA
<b>1st DISTRICT</b>				
Gibson	11	11	11	11
Perry	7	7	7	7
Pike	2	2	2	2
Posey	6	6	6	6
Spencer	5	5	5	5
Vanderburgh	264	256	268	249
Warrick	6	6	6	5
TOTAL	301	293	305	285

### 2nd DISTRICT

Daviess- Martin	18	18	18	13
Greene	16	16	16	12
Knox	41	41	45	43
Owen-Monroe	95	89	96	84
Sullivan	10	10	13	12
TOTAL	180	174	188	164

### 3rd DISTRICT

Clark	54	53	53	46
Dubois	26	26	23	21
Floyd	44	44	46	44
Harrison- Crawford	9	9	9	9
Lawrence	37	37	37	31
Orange	8	8	6	6
Scott	7	7	8	8
Washington	7	7	7	7
TOTAL	192	191	189	172

### 4th DISTRICT

Bartholomew- Brown	61	61	64	52
Dearborn- Ohio	15	15	15	14
Decatur	10	10	10	9
Jackson- Jennings	19	19	21	21
Jefferson- Switzerland	29	29	28	25
Ripley	11	11	11	8
TOTAL	145	145	149	129

### 5th DISTRICT

Clay	12	10	15	15
Parke- Vermillion	15	15	14	14
Putnam	18	18	20	20
Vigo	120	119	121	115
TOTAL	168	162	170	164

### 6th DISTRICT

Fayette- Franklin	16	16	18	17
Hancock	27	27	25	25
Henry	38	38	38	33
Rush	12	12	12	12
Shelby	21	21	20	17
Wayne-Union	71	70	75	68
TOTAL	185	184	188	172

### 7th DISTRICT

Hendricks	22	22	23	19
Johnson	36	36	36	33
Marion	1093	1075	1090	1083
Morgan	21	21	21	19
TOTAL	1172	1154	1170	1154

### 8th DISTRICT

Delaware- Blackford	132	128	127	96
Jay	16	16	17	12
Madison	108	108	103	75
Randolph	17	17	16	10
TOTAL	260	269	263	193

### 9th DISTRICT

Benton	10	10	9	8
Boone	18	18	16	15
Clinton	14	14	15	12
Fountain- Warren	11	11	12	11
Hamilton	14	14	17	13
Jasper	8	8	9	9
Montgomery	23	22	24	24
Newton	5	5	5	5
Tippecanoe	144	142	154	141
Tipton	11	11	10	10
White	7	7	9	7
TOTAL	265	262	280	255

### 10th DISTRICT

Lake	454	450	440	407
Porter	64	67	78	76
TOTAL	523	517	518	483

### 11th DISTRICT

Carroll	8	8	8	8
Cass	35	35	32	26
Grant	79	79	79	77
Howard	71	70	72	69
Huntington	18	18	16	15
Miami	13	13	13	13
Wabash	29	29	30	22
TOTAL	253	252	250	230

### 12 DISTRICT

Adams	12	12	12	12
Allen	312	311	317	292
DeKalb	19	19	19	15
LaGrange	11	11	11	9
Noble	12	12	14	13
Steuben	10	10	13	13
Wells	46	40	44	44
Whitley	15	15	15	15
TOTAL	437	430	445	413

### 13th DISTRICT

Elkhart	111	111	114	104
Fulton	7	7	8	7
Kosciusko	12	12	13	13
LaPorte	94	93	101	86
Marshall	20	20	19	18
Pulaski	5	5	4	1
St. Joseph	239	237	243	242
Starke	8	8	8	7
TOTAL	496	493	510	478



## SUMMARY

1st District	301	293	305	285
2nd District	180	174	188	164
3rd District	192	191	189	172
4th District	145	145	149	129
5th District	165	162	170	164
6th District	185	184	188	172
7th District	1172	1154	1170	1154
8th District	273	269	263	193
9th District	265	262	280	255
10th District	523	517	518	483
11th District	253	252	250	230
12th District	437	430	445	413
13th District	496	493	510	478
	<u>4,587</u>	<u>4,526</u>	<u>4,625</u>	<u>4,292</u>

DONALD M. KERR, M.D.,  
*Chairman*

VINCENT J. SANTARE, M.D.

JAMES H. GOSMAN, M.D.

JOE DUKES, M.D.

GILBERT M. WILHELMUS, M.D.

HUGH K. THATCHER, JR., M.D.

rules governing it require. A greater attempt is being made at the local level to settle differences before the state committee is involved.

The revised Purposes, Rules and Procedure of the Grievance Committee, as mandated by the 1967 House of Delegates, has been sent to every member of the ISMA and is sent to physicians when they become members of ISMA.

The Grievance Committee wishes to thank the members of ISMA who have been called upon to assist in discharging its responsibility. We have received excellent help.

RICHARD S. BLOOMER, M.D.,  
*Chairman*

WILLIAM D. PROVINCE, M.D.

EUGENE S. RIFNER, M.D.

KENNETH WILHELMUS, M.D.

THOMAS C. TYRRELL, M.D.

WILLIAM C. STRANG, M.D.

HARRY L. CRAIG, M.D.

LAWRENCE K. MUSSELMAN, M.D.

## Grievance Committee

The Grievance Committee has held only one meeting during the year, which is an indication to the members that more complaints are being handled at the local level, and the county medical societies are to be commended for this. As previously reported, the most prevalent complaints received by the committee are those of misunderstanding of charges by the physicians and the lack of communications between the patient and the physician.

As of July 15, 1973, 13 new cases were filed, 4 of which have been referred to the local county medical society. The other nine cases have been handled in a routine manner and have been resolved in a satisfactory manner.

The ISMA Grievance Committee continued to follow the procedure of past years. (1) Receipt of complaint is acknowledged by a letter which states that action can proceed only after receiving the complainant's permission to forward a full copy of the complaint to the physician or physicians named therein along with identification of those filing the complaint. (2) Should the requested permission be given, the physician named is asked to attempt a personal settlement of the complaint. (3) Should the physician be unsuccessful or should he request that his county medical society attempt settlement, the matter is so referred, with the ISMA Grievance Committee retaining the responsibility as the

## Future Planning

Your Future Planning Committee had scheduled four meetings for the year 1972-73. For a variety of reasons two meetings were held and both were well attended. These meetings were held on January 20th and March 10th of 1973. The Future Planning Committee again voted unanimously to recommend to the Board of Trustees that the ISMA headquarters be enlarged. Survey of the headquarters indicates that there is no available space for additional activities, yet ongoing activities continually occupy more and more of the existing space, and, as previously recommended, if planning does not progress, we will find ourselves in a position where it is imperative to implement a program for which there is no available space. The Board of Trustees was again requested to establish a new building committee to begin planning for accommodation of the continuously escalating activities.

The Committee undertook a review of the testimony given to the Special Reference Committee Meeting held during the annual convention of 1972. It was the consensus of the Committee that the open hearings were primarily ventilatory in nature, but of very significant value to both the officers, Board of Trustees, and membership. It was difficult to find positive suggestions upon which the Future Planning Committee could make recommendations. There were a number

of valuable suggestions, all of which have been referred to the Board of Trustees for evaluation. Further details of recounting of these suggestions is contained in the minutes of the Future Planning Committee, and are on file at the headquarters office.

It is recommended that at least every other annual session have a special reference committee to hear the testimony of any member of ISMA who desires to attend this special committee. Resolution No. 4 is submitted for consideration of the House.

The Future Planning Committee also has studied in great detail Public Law 92-603 (which embodies the concept of PSRO). It was the unanimous opinion of The Future Planning Committee that ISMA should obtain legal counsel and prepare a charter for a foundation that would encompass the areas that would serve as an umbrella PSRO, should the House of Delegates vote to proceed with further co-operation with this law. This matter was referred to the Board of Trustees for further consideration.

It is doubtful that the current structure of the Future Planning Committee can be of great value to the officers and Board of ISMA, with its current composition. It is strongly recommended that at least 80% of the members of The Future Planning Committee be members of the Association that have been in practice less than five years. It is recommended that at least one past-president be a member of the Future Planning Committee, and that should be one who has served within five (5) years of the appointment for which he will serve on the Committee. We believe it imperative that continued in-put from the president, president-elect, and board chairman be available on an ex-officio basis, as is possible.

LOWELL H. STEEN, M.D.,  
*Chairman*

GEORGE M. HALEY, M.D.

MAURICE E. GLOCK, M.D.

JAMES FITZPATRICK, M.D.

RALPH V. EVERLY, M.D.

STANLEY CHERNISH, M.D.

PATRICK J. V. CORCORAN, M.D.

PETER R. PETRICH, M.D.

DeWAYNE HULL, M.D.

JAMES T. ANDERSON, M.D.

JAMES H. GOSMAN, M.D.

JOE DUKES, M.D.

GILBERT WILHELMUS, M.D.

DONALD KERR, M.D.

FRANK B. RAMSEY, M.D.



## Student Loan Committee

The Student Loan Committee had no requests for loans, and consequently made no new loans during the past year. To date, 108 loans, totalling \$95,500, have been granted. Actually, 18 loans this year were converted to installment loans for a total of \$18,548.25. No notes are in interim. All are moving well.

The loan fund of ISMA from 1955 to 1963 had loaned money to 118 students, in all, a total of \$58,458.36. This total amount has been repaid. The Guaranteed Loan Plan with Indiana National Bank was started in December of 1963, and has on deposit \$20,810 of ISMA money. This guarantees loans up to \$260,000.

The general good economic situation of Indiana and the financial support of the students, because of working wives, and the fact that medical student jobs are good paying have minimized the need for student loans. AMA-ERF is a common source of loans for students, and these loans are available through the medical school dean's office and his AMA-ERF representative.

MALCOLM O. SCAMAHORN, M.D.,  
*Chairman*

JAMES H. GOSMAN, M.D.

GILBERT M. WILHELMUS, M.D.

VINCENT J. SANTARE, M.D.

HUGH K. THATCHER, JR., M.D.

GLENN W. IRWIN, JR., M.D.

## Medical Legal

The Medical-Legal Review Committee met February 4, 1973, in the headquarters of the Indiana State Medical Association with the chairman, John W. Beeler, M.D. and Joseph G. Weber, M.D. in attendance. Meeting with the Committee were President James J. Stewart, representing the Bar Association. There was considerable discussion about the advantages of forming some type of medical-legal review committee in those cases of alleged malpractice. The various state organizations currently having some type of joint review were discussed with special emphasis on the "Virginia Plan." It was decided to investigate this plan further, as to its function and to obtain suggestions from them regarding its implementation in Indiana.

Mr. Stewart agreed to obtain information from the Insurance Commissioner of the state of Indiana as to the number and types of malpractice cases over a one-year period in Indiana, so that we may obtain some actual data as to the problem as it currently exists in our State.

In addition, an experience of the San Francisco plan of medical-legal review is currently being investigated and the chairman has accumulated some early material, which hopefully will be augmented further by the last of this year.

Dr. Gosman urged obtaining data such as that requested from Mr. Stewart so that both physicians and attorneys, working together, may draft such legislation as necessary, if the proposed "Joint Medical-Legal Plan for Screening Medical Malpractice Cases" is adopted by the Society.

In addition, the Committee reviewed a complaint which had been referred to it, and the action of the Committee was to refer the complaint to the Grievance Committee of the ISMA.

The Committee also participated in a joint medical-legal program of the Marion County Medical Society and the Indianapolis Bar Association, which was presented to the two societies in November 1972. The attendance at this program indicated the interest of members in the Professional Liability situation, and there are both local and state plans for further joint meetings.

The Chairman of this Committee was personally disappointed in the report of the Secretary's Commission on Malpractice, which was presented early this year. There are very few indications that the current trend of increasing number of suits and inappropriate financial judgments will alter in any way in the future.

### RECOMMENDATIONS:

- 1) Evaluate the size of the malpractice problem which currently exists in Indiana with the help of the State Bar Association.
- 2) Select a Joint Medical-Legal Plan for Screening Malpractice cases, such as is now being used in some other state in a satisfactory manner (i.e. Pima County Plan of Arizona, the plan currently used by the Medical Society of Virginia).
- 3) Plan a joint meeting with the Marion County Medical Society and the corresponding societies of the State and Marion County Bar Associations for the fall or early winter of 1973-1974.

JOHN W. BEELER, M.D., *Chairman*  
JOSEPH G. S. WEBER, M.D.  
ROBERT R. KOPECKY, M.D.  
GEOFFREY SEGAR  
JAMES J. STEWART  
JOHN T. HUME, III

## Sports and Medicine

For the fourth year, this Committee has met in order to provide more complete medical care to young athletes and athletic events in Indiana, and to better coordinate and study certain aspects of the provision of care to Indiana's athletes. Therefore, this Committee has met and discussed with officials of the Indiana High School Athletic Association and representative coaches many topics regarding health and care of athletes under their jurisdiction. Informally in our meetings, many medical suggestions have been made regarding different training and competitive techniques, and also what can be done to improve these. More directly, the Committee on Sports and Medicine has accomplished some of the following.

A Directory was assembled comprising nearly 300 physicians throughout the state of Indiana who have a special interest in athletic medicine. A questionnaire is now being formulated and will be sent to these physicians in order to learn of their qualifications, educational background, and activities in sports medicine. This directory is hoped to be a resource from which our Committee can expand and gain insight on particular problems around the state in athletic medicine. This directory might also serve to help local communities solve problems in athletic medicine by having some qualified person designated to assist them.

A meeting of one half day was planned by this Committee for the football coaches of Indiana to be held in July 1973 in conjunction with their meeting in Bloomington. This program will deal with facets of athletic injuries that can be both educational and helpful to these particular coaches. Additionally, a program to coordinate meetings regarding sports medicine throughout the state is in progress. This will afford doctors interested in sports-medicine an opportunity to attend meetings on athletic medicine in their particular areas once or twice yearly. New and varied topics of athletic medicine can then be introduced.

The main topic of discussion at our meetings was that of athletic training and how the ISMA can help improve the level of athletic training in high schools, and how we should proceed to require high schools to employ athletic trainers qualified to take care of athletic injuries. The Committee is investigating numerous avenues to approach this problem. It was thought by the Committee that



legislative steps should be taken to encourage each high-school to staff its athletic department with one qualified trainer. Any method which can be used to gain this goal should be instituted. The Committee, however, will recommend to the Indiana State Commission of Higher Education, and the superintendent of the Department of Public Instruction of the state of Indiana, that:

"An educational program be developed in all Indiana teacher training institutions to educate and develop athletic trainers" (Resolution 71-13 House of Delegates ISMA 1971). The Committee feels, however, because of the immediacy of the situation, we should encourage training of students and teachers in our secondary schools to act in the capacity of athletic trainers under the guidance of a team physician. Individual training should be done through means of athletic training seminars and summer camp programs, such as being conducted by the Kramer Company, which sponsors such workshops throughout the country. The Committee and the Indiana State High School Athletic Association will work jointly to provide the latter two

programs in the following year.

The Committee on Sports and Medicine helped this year to formulate and endorse the new physician-student health certificate that is required by the IHSAA for all of its member schools' participants in athletics.

Recommendations made by this Committee in 1972-73:

1. A physician will be appointed to act as medical advisor to each of the 10 major sports of the Indiana State High School Athletic Association, and act as liaison between his sport and the Committee on Sports and Medicine.

2. That county medical societies sponsor one-day meetings yearly to acquaint physicians with new ideas in sports medicine.

3. That the "crack-back" block be completely eliminated from high school level of football.

4. In all all-star games the players be allowed to use their equipment from high school. Injuries should decrease with proper fitting of the equipment previously found satisfactory by the player.

5. That the football be allowed as

part of the equipment for the three day pre-season training for football.

6. "Wrestle Backs" that require wrestling up to five times a day for individual participants is too excessive, and this policy should be altered.

7. Present practice requirements by the IHSAA should remain unchanged, and women's sports should adhere to the same schedule.

8. That the same particular care taken for the prevention and treatment of injuries to male athletes be afforded to female athletes.

BRAD BOMBA, M.D.,

*Chairman*

THOMAS A. BRADY, M.D.

JAMES H. BELT, M.D.

GILBERT M. WILHELMUS, M.D.

ARTHUR L. MOSER, M.D.

GARLAND D. ANDERSON, M.D.

LESLIE M. BODNAR, M.D.

ALOIS E. GIBSON, M.D.

JERALD E. SMITH, M.D.

WILLIAM B. FERGUSON, M.D.

PAUL MACRI, M.D.

CHARLOTTE H. KERR, M.D.

BOB OTOLSKI

WARD BROWN

PHIL N. ESKEW



# Reports of Commissions

## Aging

Your Commission on Aging this year undertook the task of trying to reach some solutions to the problems in the Medicare and Medicaid systems.

We first met with a number of key people, including E. Frank Ellis, M.D., director of Health for Region Five of the Department of Health, Education, and Welfare.

Following that meeting, your Commission held several meetings and drafted a position statement which was endorsed by the ISMA Board of Trustees.

The text of that statement follows:

### **Position Statement on Medicare and Medicaid of the Commission on Aging of the Indiana State Medical Association**

Economic realities and personal and professional frustrations may drive some physicians away from the care of Medicare and Medicaid patients and both programs could eventually become empty promises for lack of doctor participation.

Unless the situation is reversed and some sensible and acceptable arrangements are made to correct what presently borders on chaos, there will be fewer doctors willing to provide care for Medicare and Medicaid patients, much as they would like to do so.

Doctors, in increasing numbers, are refusing to be discriminated against as providers. Perhaps the public and politicians are not presently interested; but to the physician, who is a taxpayer trapped between rising expenses and Medicare and Medicaid payments below what he normally charges, there is no alternative.

Only professional providers of services are expected to accept a forced discount of their charges and then, as taxpayers, to subsidize public assistance. No other provider is expected to purvey a quality product, to struggle through a maze of paperwork, confusion as to patient benefits, conflicting regulations, misunderstanding and misinformation and then to accept reduced payment.

Physicians have every right to object to such cavalier treatment and they are doing so. What, for instance, can the rationale be for reducing a fee for a nursing home visit from \$10.00 to

\$1.56 or 48¢ or even 16¢, except to make the doctor the scapegoat for the programs' shortcomings under the guise of "cost containment"?

How can any physician be expected to provide adequate care for patients in extended care facilities under such a system? Physicians, as a group, by the very nature of their calling, have more than their share of altruism and they exercise it in many ways. But to suppose that they will give away their skill, knowledge and judgment because politicians have made commitments they cannot honor is not only unrealistic, it's absurd.

Secrecy, again under the guise of "cost containment," pervades the Medicare and Medicaid programs. Physicians cannot learn how the allowed fees are determined. To deny them such information is a situation which can only be founded on mistrust. Physicians cannot be blamed for refusing to participate under those terms when the system finally fails because it is unworkable. Such secrecy in a program involving public funds is ridiculous and probably unconstitutional, especially when payments to physicians are not uniform.

The Social Security Administration has stated that physicians' charges for services under Medicare have decreased from 1966 through 1971. We don't doubt it! We believe that it is because physicians have really subsidized the program in that their usual and customary fees have been reduced arbitrarily without credit for doing so. Physicians are being told "This is not allowed" and "That is not allowed" by non-medical persons screening claims and reversing the opinions of physicians who are the only people trained and expected to provide proper health care.

The Medicare and Medicaid programs are heading for real trouble because physicians are withdrawing for the reasons set forth here, and other reasons.

We are interested in keeping physicians in the programs to give quality medical care to those who need it. The physicians will more likely stay, we submit, provided:

1. They are fairly compensated for the services they render based on reasonable fees geared to variations in the cost of living and established upon proper consultation with physicians.
2. The billing procedure is simplified.
3. Nursing home visits are approved on the basis of need and the need

is decided by physicians and not by non-medical personnel.

We further submit that if a patient does not have his or her own personal physician, extended care facilities make ethical arrangements with private physicians or groups of physicians to provide quality medical care.

We further submit that if a patient does not have his or her own personal physician, provision should be made by the extended care facility for ethical arrangements with a physician or group(s) of physicians to provide quality medical care.

Only physicians can give Medicare and Medicaid patients the professional medical care they need.

It is the hope of the Indiana State Medical Association that, in the interest of patients under these government programs, recognition be given to the problems herein cited and appropriate steps taken to reverse the current trend.

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We respectfully request the House of Delegates of the Indiana State Medical Association to consider the following resolution:

**RESOLVED, THAT THE HOUSE OF DELEGATES OF THE INDIANA STATE MEDICAL ASSOCIATION HEREBY ENDORSES THE POSITION STATEMENT OF THE ISMA COMMISSION ON AGING RELATIVE TO THE MEDICARE AND MEDICAID PROGRAMS AND MANDATES THE COMMISSION TO CONTINUE ITS WORK TOWARD THE SIMPLIFICATION OF THE MEDICARE AND MEDICAID SYSTEMS IN THE BEST INTEREST OF THE AGED.**

Your Commission also respectfully requests that the House of Delegates consider this resolution:

**RESOLVED, THAT THE HOUSE OF DELEGATES OF THE INDIANA STATE MEDICAL ASSOCIATION DOES HEREBY URGE THE ESTABLISHMENT OF A CHAIR OF GERONTOLOGY AT THE INDIANA UNIVERSITY SCHOOL OF MEDICINE IN THE INTEREST OF PROVIDING BETTER HEALTH CARE FOR GERIATRIC PATIENTS.**

At the time of the submission of this report your Commission on Aging is preparing to meet again with the same group of local, state and federal officials



we met with February 4 to continue our work.

- ALBERT M. DONATO, M.D.,  
*Chairman*
- JOHN D. WILSON, M.D.
- JOSEPH C. DUSARD, M.D.
- A. W. CAVINS, M.D.
- CLOYD L. DYE, M.D.
- THEODORE R. HAYES, M.D.
- W. MARTIN DICKERSON, M.D.
- DANIEL RAMKER, M.D.
- JAMES McLAUGHLIN, M.D.
- NATHAN SALON, M.D.
- PETER CLASSEN, M.D.
- MRS. C. B. LADINE

Constitution and Bylaws

Bylaws

The Commission on Constitution and Bylaws is proposing the following changes in the Bylaws in order to carry out recommendations made to the Commission:

Chapter IV, House of Delegates

Be It Resolved that Section 1 of Chapter IV of the Bylaws be amended by adding a new and additional paragraph to read as follows:

“Nominations for officers of the Association may be made at any meeting of the House of Delegates.”

Be It Resolved that Chapter IV, Section 2, of the Bylaws be amended by adding a new and additional paragraph between paragraphs one and two which will read as follows:

“All sections listed in Chapter III, Section 1, of these Bylaws shall be entitled to send to the House of Delegates each year one delegate and one alternate delegate with the right to vote.”

Chapter IV, House of Delegates

Be It Resolved that Section 2 of Chapter IV of the Bylaws be amended by striking the last sentence of the last paragraph and substituting the following:

“No one shall be entitled to a seat in the House of Delegates unless his credential card as a delegate or alternate, properly signed by the secretary of his county society, is presented to the Committee on Credentials at the time of the Annual Convention.”

Chapter XXX, Reference Committees

Be It Resolved that Chapter XXX, Section 1, of the Bylaws be amended by striking the last sentence of the first paragraph and substituting the following:

“Appointments of these reference com-

mittees shall be made by the President with the assistance of the Speaker. Appointments shall be made in time for them to be published in THE JOURNAL and the Handbook prior to such Annual Convention.”

Be It Further Resolved that Chapter XXX, Section 1, of the Bylaws be amended by inserting the words “with the assistance of the Speaker” after the word “President” in paragraph two.

Be It Further Resolved that Chapter XXX, Section 1, of the Bylaws be amended by inserting the words “at least” after the word “of” and before the word “five” in paragraph three, line one.

Constitution

The following Constitutional amendments are being proposed for initial action in the 1973 House of Delegates. If adopted, they would then have to lay over for one year until final action could be taken in 1974.

Article IV, Composition of the Association

Be It Resolved that Section 1 of Article IV be amended by striking the entire Section 1 as now printed and substituting the following:

**Section 1.** This Association shall consist of Active Members, Associate Members, Intern and Resident Members, Senior Members, Honorary Members, Disabled Members, Distinguished Members, Military Service Members and Public Health Service Members.

Be It Further Resolved that Section 4 of Article IV be renumbered Section 5 and that a new Section 4 be substituted to read as follows:

**Sec. 4.** Student Members. Students who hold active membership in the Indiana Chapter Student American Medical Association and who are members of a component county medical society which grants active membership therein only on a basis that includes membership in the district medical society and in the Indiana State Medical Association, shall have all the rights and privileges of this Association. (Old Sections 5 through 8 be renumbered 6 through 9)

Be It Resolved that Section 9 of Article IV of the Constitution be renumbered Section 11 and a new Section 10 be substituted to read as follows:

**Sec. 10.** Military Service Members and Public Health Service Members. Any physician who is actively engaged in the military service or public health

service shall be eligible for membership in the Association without payment of membership dues.

Be It Further Resolved that in addition to being renumbered Section 11, Section 9 of Article IV of the Constitution be amended to read as follows:

**Sec. 11.** Rights and Privileges of Members. Active members, intern members and resident members, senior members, military service members, public health service members and disabled members shall have the same rights and privileges except as follows:

(a) Senior members shall not be required to pay membership dues in the State Association.

(b) If senior members, military service members and public health service members desire to receive THE JOURNAL of the State Association, they shall pay the regular subscription price therefor.

(c) Senior members, military service members and public health service members who desire the benefit of medical defense as provided by the Bylaws of this Association shall pay the amount stipulated in Section 1, Chapter XXXIII of the Bylaws for this coverage.

(d) Honorary members hereafter elected shall hold such membership as an honor and distinction and shall have the right to attend meetings of the Association. They shall have the privilege of participating in discussions but shall have no right to vote or to hold elective office. They shall not be required to pay membership dues in the State Association.

(e) All such disabled members, as defined above, shall receive association membership cards and THE JOURNAL of the Association without charge.

Article V, House of Delegates

Be It Resolved that Article V, paragraph one, be amended to read as follows:

The House of Delegates shall be the legislative and business body of the Association and shall consist of (1) delegates, or their designated alternates, elected by the component county societies; (2) the Trustees, or their designated alternates, (3) the ex-presidents of the Indiana State Medical Association, (4) the delegate or the designated alternate delegate of the Indiana Chapter Student American Medical Association, and (5) delegate or their designated alternate delegate elected by their respective Section. The following shall be ex officio members:



the President, the President-elect, the Executive Secretary, the Treasurer and Assistant Treasurer of this Association, the Speaker and Vice Speaker, and the delegates to the American Medical Association, all without the power to vote, except in case of a tie, when the person presiding shall cast the deciding vote.

JOHN M. RECORDS, M.D., *Chairman*  
BERNARD B. ROSENBLATT, M.D.  
PAUL B. ARBOGAST, M.D.  
ELI GOODMAN, M.D.  
IVAN T. LINDGREN, M.D.  
GLEN WARD LEE, M.D.  
WALLACE A. SCEA, M.D.  
WILLIAM J. MILLER, M.D.  
GILBERT H. WHITE, M.D.  
EVRETT SMITH, M.D.  
WILLIAM B. HUGHES, M.D.  
CHARLES PLANK, M.D.  
MALCOLM WREGE, M.D.  
LESTER RENBARGER, M.D.  
GORDON S. FESSLER, M.D.  
WALLACE C. HILL, M.D.  
MRS. THOMAS JOHNSON

## Governmental Medical Services

### Commission Reports

The Commission held several meetings and telephone conferences in the past year.

Mrs. John Stanley, Muncie, liaison representative from the Women's Auxiliary, has joined our meetings. We have been most pleased to have her join us in our deliberations.

CHAMPUS claims of unusual nature have been reviewed by the commission in meetings by telephone. In the state of Indiana the CHAMPUS program operates well and is highly regarded by the superior officers in Denver. We have had very few rebuttals on claims and from the decisions of the commission.

The State Rehabilitation Commission met with our commission and explained some of the programs on the disability insurance examinations, particularly in the specialty groups. We have yet to receive from them a statement as to what fees they will pay for special examinations above and beyond the first examination.

During the year we heard from many people. Mr. Wayne Stanton, director of the Public Welfare Department, met with the commission early in the year. At that time we were joined by the Commission on Legislation. Mr. Stanton brought to the commission some important information. He brought us up to

date on the Medicaid program and stated for the year 1972 the largest amount paid in money was for nursing care, with pharmacy being second. The Indiana doctors received about 10.87% of the dollars paid out, which is about the same as in previous years. We were also informed that there are approximately eight to ten physicians in the state who appear to over-utilize the Medicaid program.

The question of "Who has set the usual and customary fee up to now?" was raised to Mr. Stanton, but the answer was most ambiguous. We could not get an answer as to who sets the usual and customary fee in the Medicaid program. Mr. Stanton informed the commission that the Welfare Department needs about two additional doctors to review the claims in the state. This is one reason why there is an existing backlog of claims for disability, etc.

Starting January 1974, Mr. Stanton informed us that there will be federalization of three programs—old age, aid to the blind, and aid to the disabled. This will increase by about 300% the number of persons given aid. *And for the first time* aid will be paid from Medicare to ages below 65. One bright hope: with this increase they must meet strict requirements. The commission also learned that Indiana is one of the lowest payers to the number on welfare—less than one-half the national average.

Mr. Stanton gave us information about the small booklet that is available which explains quite well the differences between the Medicaid and Medicare programs. I believe this booklet has been mailed to many members of the ISMA. Much confusion still exists, and it is hoped that the ISMA, in mailing these booklets to our membership, will clear up this confusion.

ADC (Aid to Dependent Children) is going up about 10% a year due to the fact that the state mental hospitals have turned out about 5,000 patients a year to be placed on welfare and Medicaid at the county level. Also, our society requires higher skills and learning needed for jobs as our society improves. Another reason for this increase is that the domestic family structure has greatly deteriorated in the last few years. This should come as no great news because we realize that there are a number of bad family circles. Free love, fewer marriages have added to an increase in the ADC rate. Some adoption agencies have gone out of business. There are fewer desirable adoptable families remaining.

Continuing with the ADC discussion, there was comment about examinations for those under 21 years of age, which will be probably part of the program. It was estimated that this would cost from 90-to 100-million dollars more—not very possible. In May 1973 the Welfare Department hopes that they may ask for a gross lay screening—"Is the child sick or well?"—then referrals will be made for care as needed.

The question was put to Mr. Stanton about the Welfare Department and their policy on abortions, and he stated as follows, "They will not push abortions, but will pay for abortions."

We were also reminded by the Welfare Department heads that it is impossible to get off the welfare rolls (unless the welfare recipient requests it). It is hoped the needs schedule will be reduced. We were informed that there is a lot of false information concerning the size of welfare checks. The maximum a mother with one child can receive is \$115.00 per month; and for each additional child not more than one dollar, per day, per month, is payable.

We met with several members of the State Medical this year, some of them being ophthalmologists who appeared before the commission. They wish to have a hearing on why Medicare fee allowances were changed from 1972 to 1973. We listened diligently and tried to help them out and steer them in the best manner that we knew how. I would like to quote to you part of a letter from one of the doctors who met with the commission. It is as follows:

"Your time is not wasted. I got a fine, long, detailed phone call from one of the members of your commission, Dr. Trachtenberg, this week before my appeal and his advice was outstanding. Peer review is time consuming and humbling but we must do it. Your enthusiasm for hearing our problems is surely rewarding. The Bulletin and the Journal should carry more news items from your deliberations so that all members of the profession can benefit from your experience. Specialty groups must pass the word around. Their response (Blue insurance) is to find fault with the doctor's work or to reel off several pages of doubletalk."

The commission hopes that we can have a realistic approval to the PSRO program, and the commission would like to suggest that recent development of PSRO programs for non-government patients be started to gain experiences for



the government-type of patients which will come at a later date.

In May of 1973, the Honorable Governor Otis R. Bowen, M.D., named Dr. Jack B. Hardigg of Indianapolis to the new post of Medical Director of Indiana, Department of Correction. The commission has worked for many years to have a medical officer in the department of corrections, and we are especially proud of this achievement.

The staff of ISMA and the CHAM-PUS office have been always helpful and successful in completing our reports and meeting arrangements.

- JEROME E. HOLMAN, JR. M.D.,  
*Chairman*  
ROBERT E. ARENDELL, M.D.  
CHARLES L. McKEEN, M.D.  
FRANCIS H. GOOTEE, M.D.  
FRED D. HOUSTON, M.D.  
O. LYNN WEBB, M.D.  
GEORGE E. BRANAM, M.D.  
LOWELL R. STEPHENS, M.D.  
LEE H. TRACHTENBERG, M.D.  
GEORGE A. TEABOLDT, JR., M.D.  
MICHAEL J.  
MASTRANGELO, M.D.  
PAGE E. SPRAY, M.D.  
GLEN V. RYAN, M.D.  
CHARLES R. ALVEY, M.D.  
MRS. JOHN STANLEY

### Interprofessional Relations

The Commission first met on January 7, 1973. It was decided that the most pressing order of business was the feasibility of a joint practice commission with the Nurses Association. This had been recommended by the AMA, and Dr. Gabriel Rosenberg reported, following a meeting at Chicago, at which time this was discussed in detail.

After considering Dr. Rosenberg's report and committee discussion, it was felt that the Indiana State Medical Association should make overtures to the Indiana State Nurses Association and explore the feasibility of forming a joint practice committee. This was based on the fact that it was felt that nurses should be encouraged to develop further capabilities in delivering primary health care, in that their preliminary training qualified for this. They had set standards for developing nurses, which could be used as a basis for expansion. Such a committee would give the medical profession considerable control over people who are going to be involved in the primary delivery of medical care as a physician's assistant.

On Sunday, April 8, 1973, the Commission met again along with representatives from the Indiana State Nursing Association. The decision was made to form a joint practice commission in Indiana, consisting of 16 members with equal representation from the Indiana State Medical Association and the Indiana State Nurses Association. It was recommended that this commission be established to survey the entire relationship between physicians and nurses, not only in areas of developing physician's assistants, but in the areas of education, legislation, etc.

Following this, a third meeting was held. At that time, the Committee recommendations were made to Dr. Gosman for the membership of this committee. These recommendations were made to cover the various areas of the various interests of the state, and eight members were suggested to fill this commission. Dr. Gosman, the president, was to have the final decision as to these selections. The Commission was to operate as an ad hoc committee for the time being, in that it would require approval of the House of Delegates to become a permanent Commission.

The Interprofessional Relations Committee felt that, following the establishment of this committee, the Interprofessional Relations Committee should go into other areas concerning the relationship of medical staffs to administration in hospitals, legislation; and these meetings are planned for the future.

- WARREN COGGESHALL, M.D.,  
*Chairman*  
ALBERT S. RITZ, M.D.  
JACK L. SHANKLIN, M.D.  
IGNACIO B. CASTRO, M.D.  
GERALD BOWEN, M.D.  
RICHARD L. VEACH, M.D.  
MARK E. SMITH, M.D.  
CLYDE G. CULBERTSON, M.D.  
AMBROSE PRICE, M.D.  
PAUL E. LUDWIG, M.D.  
MITCHELL E. GOLDENBURG, M.D.  
J. DEAN GIFFORD, M.D.  
MARVIN PRIDDY, M.D.  
WILLIAM J. STOGDILL, M.D.  
FRED DIERDORF, M.D.  
RICHARD W. HOLDEMAN, M.D.  
MRS. OTIS BOWEN

### Legislation

The Commission on Legislation under the chairmanship of Donald E. Wood, M.D., had a very successful year in the state legislature. A full and complete

report of the Commission on Legislation's activities during the 1973 session of the Indiana General Assembly was distributed to every ISMA member in June of 1973. This report was prepared by Mike McDermott, the Legislative Assistant for the Indiana State Medical Association. Mike joined our staff on January 8, 1973, the opening day of the 1973 Legislative Session, and worked closely with the commission on all legislative matters.

In addition to meetings held between legislative sessions, the Commission on Legislation met regularly during the months of January through April of 1973 to discuss and review bills pending before the General Assembly. These meetings were held approximately every three or four weeks. The meetings during the month of January were devoted to screening the total of 1,416 bills which had been introduced to determine which bills the Commission would support, oppose, or take for information only. The meetings during the remainder of the legislative session were used to review the progress of the bills which were of interest to the Commission. In all, 104 health related bills were monitored by the Commission. Of these 15 bills were actively supported, 15 were actively opposed, and the remaining 74 were taken for information.

A bill status system was developed in an effort to keep members of the Commission and also county medical societies updated on the progress of each individual bill through the legislative system. Information on specific bills of major importance to the ISMA was also sent to county medical societies and to individual physicians throughout the state. These physicians were then encouraged to contact their representatives in the state legislature.

The Commission has also held several meetings since the close of the 1973 session for the purpose of preparing a legislative program which will be presented to the House of Delegates and which will contain bills that the ISMA intends to have introduced for the 1974 session of the legislature. The major piece of legislation which will be presented by ISMA is the new Medical Practice Act.

The interest and enthusiasm of the members of the Commission was evident in their attendance at the many meetings we held. As chairman, I would like to express my thanks for the hard work and cooperation of the members of our Commission as well as the cooperation



and interest shown by the legislative representatives in the various county medical societies.

- DONALD E. WOOD, M.D.  
*Chairman*  
DANIEL C. TWEEDALL, M.D.  
ROBERT ROSE, M.D.  
IVAN A. CLARK, M.D.  
WILLIAM BANNON, M.D.  
JOHN A. DAVIS, M.D.  
JOHN PANTZER, M.D.  
RICHARD L. REEDY, M.D.  
MAX N. HOFFMAN, M.D.  
A. P. BONAVENTURA, M.D.  
RICHARD L. GLENDENING, M.D.  
JERRY L. STUCKY, M.D.  
HARRY STOLLER, M.D.  
JAMES KIRTLEY, M.D.  
DONALD TAYLOR, M.D.  
DeWAYNE HULL, M.D.  
JOE BLACK, M.D.  
JOSEPH McPIKE, M.D.  
LEONARD W. NEAL, M.D.  
MRS. G. BEACH GATTMAN  
OTIS R. BOWEN, M.D.  
*(Governor-Honorary)*

Medical Economics  
and Insurance

The Commission on Medical Economics and Insurance held meetings November 12, 1972, March 4, 1973, and May 6, 1973, and met in joint session with the Commission on Public Information.

The primary objectives of the Commission during the past year were:

- (1) Monitoring the current ISMA Group Insurance Programs;
- (2) Attempting to finalize arrangements for inclusion in the ISMA Group Insurance Program of:
  - (a) Tax Deductible, Overhead Expense Insurance
  - (b) High Limit Major Medical Coverage;
- (3) Attempt to secure a satisfactory Group Medical Liability Coverage.

During the past year the Commission on Medical Economics and Insurance was *not* charged with any activities involving problems with Blue Shield. As a result, all such inquiries and problems were referred to ISMA officers, ISMA trustees or Blue Shield Board members. This explanation will perhaps answer some of the ISMA members' questions and criticisms regarding our lack of activity in this area.

Currently, the following Group Insurance Programs are in effect for ISMA members. These programs enjoy good

participation and have had a good actuarial experience.

*I—Group Life Insurance* — This program provides up to \$50,000 limits for individuals and professional corporations. A spouse and certain children can be included for limited amounts at small additional premiums. Conversion privileges are available. In addition, for those members under the age of 55 carrying the Group Life Policy, permanent, cash value insurance is available in an equal amount. Payments for deceased members passed \$50,000 as of mid-July.

*II—Disability Income Replacement Insurance* — is available and provides up to \$1500/month.

Programs expected to be available in late 1973—

*I—Overhead Expense Insurance* — This would be a tax deductible program available in amounts up to \$3500 maximum for members under 60 years of age. This pays 100% of office expenses for 18 months (based on actual office expenses). If death occurs prior to that time, a 3-month benefit is available, if the insured is drawing benefits. A 15 or 30-day deductible period is provided.

*II—High Limit, Major Medical Insurance* — with a \$250,000 life time maximum.

*III—Disability Insurance for Interns and Residents*

The Commission has under serious consideration two approaches for a Group Medical Liability Program. Each has advantages and disadvantages. All require a high percentage of participation of members with a built-in review mechanism by the ISMA. It goes without saying that no insurers are anxious to write this type of program without specific controls. At the direction of the Board of Trustees, further studies are being made on feasibility.

In response to a request from the Reference Committee at the 1972 Convention, the Commission approved and submitted to the ISMA Board of Trustees three forms for the use of ISMA members who desire to use "A Statement of Understanding." These forms were approved by the Board of Trustees:

PATIENT-PHYSICIAN AGREEMENT  
RESPONSIBILITY FOR FEES

I, the undersigned, recognizing that the medical insurance coverage I possess may not completely cover the fee(s) for professional service(s) rendered to me. I

hereby agree that I am responsible for said fee(s).

I authorize my physician to give notice to my medical insurance carrier(s) of this agreement.

I am aware that I may make inquiry of my physician relative to fee(s) prior to any professional service(s) required and rendered or at anytime thereafter.

Dated at \_\_\_\_\_

this \_\_\_\_\_ day of \_\_\_\_\_ 19\_\_\_\_

Signed: \_\_\_\_\_

NAME OF PATIENT  
ADDRESS

\_\_\_\_\_  
WITNESS

STATEMENT OF UNDERSTANDING

I agree that the determination of professional medical and/or surgical services to be rendered by my doctor and the fees to compensate him for these services are matters concerning my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for his services, notwithstanding any contract I may have with an insurance company, my employer or my union. Neither my doctor nor I will permit an insurance company, my employer or my union to determine what medical services I need or what fees the doctor should receive in return for these services. Any agreement that either of us may have with an insurance company, my employer or my union shall not affect our doctor-patient relationship and the decisions relating to medical care and fees. Neither my doctor nor I, as his patient, am in any way bound by any contract the other may have with an insurance company, my employer or my union.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Physician

\_\_\_\_\_  
Witness



**JOHN DOE, M.D.**  
**110 Doctor's Street**  
**Anywhere, Indiana**

Charges estimated in advance of surgery, obstetrics, etc.

OPERATION <sup>1</sup>	\$
ASSISTANT <sup>2</sup>	\$
ANESTHESIA	\$

1. Includes normal care and post-operative care. It should be understood this estimate is for normal, uncomplicated service. In the course of care, should complications require additional treatment, the total fee may be more than estimated.

2. The surgical assistant will bill the patient for his fee. When the referring physician acts as the assistant, he will bill the patient for his services.

If additional medical care is required, the physician rendering this care will bill the patient for his services.

The service and payment therefor is a contract between you and I as your physician. I hold you responsible for full payment of all charges regardless of any amount that may be paid by your insurance plan.

I acknowledge receipt of a copy of this form and agree to the terms as set forth.

Signature

The Commission on Medical Economics and Insurance considered the matter of Workman's Compensation Insurance. It is the feeling of the Commission that this matter can best be handled on an individual basis and included with the member's office insurance. The Commission would remind all members that they should check their office insurance program to be sure that Workman's Compensation is included in their office insurance. The insurance, reasonable in cost, is almost mandatory for the physician.

Meeting with the Commission on Public Information, the Commission jointly discussed the possibility of preparing an easily understood pamphlet on Insurance coverage and responsibility for completion of insurance forms, to be made available to ISMA members (similar to Medicaid and Medicare Folders)

for use in their offices. This is to be studied further.

The Commission approved the following statement on "Coordination of benefits" and referred this statement to the ISMA Board of Trustees, which adopted the statement:

"Realizing the inequities, sometimes resultant from the coordination of benefits system employed by the group health insurance carriers of Indiana, and also realizing the impact of that system on helping to control the rising cost of health insurance, and remembering the abuses of its predecessor program, the Commission on Medical Economics and Insurance recommends no action be taken at this time to supplant the coordination of a benefits system in payment of group health insurance claims. The Commission also hopes that insurers and employers will achieve better coordination of group policies offered so that such inequities are prevented in the future."

It is understood that in cases of coordination of benefits, the premiums are lower.

KENNETH O. NEUMANN, M.D.,  
*Chairman*  
THOMAS J. CONWAY, M.D.  
PAUL M. INLOW, M.D.  
LEO R. NONTE, M.D.  
ROGER F. ROBISON, M.D.  
EDWARD J. PLOETNER, M.D.  
FREDERICK EVANS, M.D.  
LARRY G. COLE, M.D.  
R. JAMES BILLS, M.D.  
JOHN L. FRAZIER, M.D.  
ROBERT C. STONE, M.D.  
WALLACE S. TIRMAN, M.D.  
JACK W. HANNAH, M.D.  
JOEL W. SALON, M.D.  
R. ADRIAN LANNING, M.D.  
MRS. MALCOLM SCAMAHORN

**Medical Education and Licensure**

The commission met on December 17, 1972, and March 4, June 10, and September 9, 1973. In addition to considering matters of regular business, some referred by the House of Delegates, the commission also considered business referred from the Board of Trustees and continued with some activities that were carried over from 1972.

The major work of the commission included: (1) ISMA-Student-Faculty Retreat (2) Accreditation of continuing medical education programs (3) ISMA-CME Awards (4) Medical Practice Act (5) Indiana University School of Medicine (6) Preceptor Program (7) House Staff (8) Legislative activities (9) Par-

ticipation of the commission in planning an educational program for the annual meeting.

1. **ISMA-Student-Faculty Retreat.** The commission helped plan the fourth annual Retreat held in Nashville on April 7 and 8. Two commission members served on the planning committee and three members participated as discussion leaders for three of the four workshops. The commission also was well represented at the Retreat and felt it was an excellent experience for all participants. The full report of the Retreat is presented elsewhere.

2. **Accreditation of Continuing Medical Education Programs.** The commission through its Subcommittee on Accreditation has developed the mechanism for an accreditation system for local intrastate continuing medical education programs—not approved by a national accrediting body. This has been approved by the AMA and will be in conjunction with the AMA Physician's Recognition Award. All institutions and organizations in the state have been polled regarding their interest in accreditation. Forty have responded and have received the questionnaire. Site visits will be arranged for eligible programs

The commission also plans to award certificates of accreditation to those institutions and organizations as they qualify.

The ISMA Board of Trustees approved the commission's request to authorize the commission to charge institutions and organizations a fee for continuing medical education accreditation surveys and for the clerical work associated with the accreditation procedure.

3. **ISMA-CME Awards.** The AMA has approved the ISMA plan of awarding a special seal to be attached to the AMA-PRA certificate for Indiana physicians completing the AMA-CME requirements. The commission through its subcommittee has requested a list of Indiana physicians qualifying for the AMA-PRA since 1970 and who are eligible for the ISMA award so that they may receive their awards at the annual meeting in October 1973.

The AMA has agreed to review the CME reports of the Indiana physicians, verify their figures, and determine their eligibility for the awards and will make this information available to ISMA.

The commission also plans to award certificates of accreditation to those institutions and organizations as they qualify.



The commission through its subcommittee is requesting that the Board of Trustees and the House of Delegates consider the employment of a director and necessary staff, to head up an office at ISMA headquarters for continuing medical education. (Refer to Resolution No. 5.)

The commission has also recommended a resolution be prepared and submitted to the House of Delegates for the purpose of revising the ISMA Constitution and Bylaws to provide for a standing Committee on Continuing Medical Education to handle the business of CME accreditation and the CME awards. (Refer to Resolution No. 6.)

**4. Medical Practice Act.** Members of the commission have continued the development of the proposed Medical Practice Act, as mandated by the 1972 House of Delegates. There have been several meetings with nurses, optometrists, pharmacists, nurse-anesthetists, anesthesiologists, podiatrists and the physician assistants representing their organizations for their understanding and assistance in the preparation of an act which is satisfactory to all. Following the third meeting, the Act was totally rewritten in legal form which included the necessary changes resulting from these meetings.

The proposed act was again taken to the Indiana State Board of Medical Registration and Examination at their meeting for their review and recommendations. Also attending were representatives from the Indiana Osteopathic Association. The proposed act has again been rewritten. It will be reviewed again by the commission and the other interested organizations and finally the State Board. At the time of writing this report it is the commission's plan to have the proposed act completed for study and action by the ISMA House of Delegates at its 1973 annual meeting with the hope of presenting it to the 1974 legislature.

**5. Indiana University School of Medicine.** At each meeting of the commission a report was made by one of the deans on the progress of the I.U. School of Medicine and its statewide system. Excellent liaison between the commission and the school of medicine has been maintained. The commission has been disappointed, however, at the lack of student participation on the commission. As in the past, the commission wishes to commend the Indiana University School of Medicine for its outstanding program

in Indiana and pledges its continued support in all phases of medical education.

The commission viewed an excellent movie produced by the I.U. School of Medicine entitled "Medical Exodus—Diagnosis and Treatment" and recommended it be shown at the annual meeting with a discussion period following the movie, with the regional center directors to serve as the panel.

**6. Preceptor Program.** The commission was advised that the number of physicians willing to serve as preceptors had increased from 40 to about 150, and approximately 60 students had signed for the program.

**7. House Staff Membership.** It was suggested, in order to get more active involvement in ISMA, each county medical society identify with house staff, get acquainted and invite them to join county societies as full members with the right to hold office and have ISMA offer full membership at a reduced fee, allowing full voting privileges. It was suggested that, for state residents, membership be in the county of their origin and, for out-of-state house staff, membership be in the county where they are training. (Refer to Resolution No. 7.)

**8. Legislative Activities.** The commission studied several bills of the legislature relating to medical education and licensure and made recommendations.

**9. Annual Meeting of ISMA.** The commission discussed the desire to assume some responsibility for the educational content of the annual meetings of the ISMA and recommend that in the future the commission have at least one joint meeting annually with the Commission on Convention Arrangements to help plan the educational activities for the conventions. (Refer to Resolution No. 8.)

The chairman wishes to thank Mrs. Willis Stogsdill, representative from the ISMA Woman's Auxiliary, and the members of the commission who contributed much support during the year. A special thanks to Eugene Gillum, M.D., chairman of the Subcommittee on Accreditation (CME) and to members of the subcommittee. Without their conscientious work, the continuing medical education program could not have reached this stage of development.

Our thanks also to the ISMA staff—to Mr. Waggener and to Mr. Bush for their help and advice, to Mr. McDermott, and especially to Mrs. Cary—all of whom worked closely with the commission in lending their assistance.

FRANKLIN A. BRYAN, M.D.,  
*Chairman*

GILBERT HIMEBAUGH, M.D.

BETTY DUKES, M.D.

GEORGE G. MORRISON, JR., M.D.

STANLEY FRODERMAN, M.D.

DAVID ELLIS, M.D.

DONALD M. SCHLEGEL, M.D.

ROSS L. EGGER, M.D.

SAMUEL C. MILLIS, M.D.

NICHOLAS L. POLITE, M.D.

SHOKRI RADPOUR, M.D.

THOMAS A. ELLIOTT, M.D.

PETER J. PILECKI, M.D.

LESLIE BAKER, M.D.

LINDLEY WAGNER, M.D.

GLENN W. IRWIN, JR., M.D.

STEVEN C. BEERING, M.D.

MERRITT O. ALCORN, M.D.

STEVEN D. BERKSHIRE

MRS. WILLIS STOGSDILL

## Public Health

The 13-member Commission on Public Health held three meetings. Eight of the members attended at least one meeting.

A number of subjects were dealt with and actions taken, as follows:

**1. Amphetamine Survey.** The Board of Trustees requested a year ago that the Commission on Public Health survey the state to see how many county medical societies have implemented the provisions of Resolution 71-5. This resolution suggested the membership discontinue the use of amphetamines, except for a certain condition such as narcolepsy and the hyperactive child. To conduct this survey, the commission asked field representatives to canvass the county medical societies in the regular conduct of their rounds and to ask:

A. Has your society followed the recommendations of Resolution 71-5?

B. If so, do members of your county medical society still comply with the moratorium?

Response to this survey was received in June as follows:

Thirty-five of eighty county societies reported. Fourteen of these thirty-five co-operated with the resolution.

**2. Recommendations of the Reference Committee that the Commission on Public Health include all drugs in its next report, not just marijuana.** The Commission on Public Health felt there was misunderstanding about this point. Our report a year ago dealt only with marijuana because this was the specific subject we were asked to write about to the President's Commission on Marijuana



and Drug Abuse. They reported only on marijuana at the end of their first year. The second half of their assignment, Drug Abuse, was the subject of the second report at the end of the second year. The Indiana State Medical Association Commission on Public Health was not asked by them for its opinion for this second report. The members of the ISMA Commission on Public Health did not feel competent to make recommendations on all drugs as recommended by the Reference Committee, and we felt any such effort on our part would not be useful in a field well covered already by specialists. We were not able to comply, therefore, with this suggestion.

3. *Position on Small Pox Immunization.* The Commission on Public Health was asked by the Reference Committee for its position on small pox immunization. The commission unanimously supports the statement which it made through one of its members, A. C. Offutt, M.D., to the Board of Trustees one year ago. Essentially, that statement says the individual physician should immunize or not, as he judges best, consistent with good medical practice.

4. *Immunizations in General.* Discussion on measles and other immunizations was held. Concern was expressed about the percentage of protected children in a community falling below a critical level, permitting epidemics (for example, of measles) to occur. Many large cities in Indiana have free clinics for immunizations, but many communities do not. It was decided that the position of the commission should be to continue to emphasize the importance of all immunizations.

5. *Junk Foods Sold in School Cafeterias.* In response to a letter from a citizen in Monroe County complaining to the local county medical society about candy and other junk foods for sale in the school cafeteria, the commission wrote a letter affirming our state policy and that of the American Medical Association as against such sales in school cafeterias.

6. *National Ambulatory Care Survey of the National Center for Health Care Statistics.* This survey is nationwide and concerns all activities of all physicians in their care of ambulatory patients. The commission endorsed the survey unanimously and recommends that physicians cooperate with it.

7. *Venereal Disease.* Again, as has occurred annually, discussion was held on the subject of special publicity and drives by the State Medical Association to fight V.D. The considered conclusion of the commission, as before, was that enough

publicity already exists, and it would not be helpful for our commission to make a special effort here. Local M.D.s and school officials are handling the subject satisfactorily with the plentiful materials which already exist and which are available through the Indiana State Board of Health.

8. *T.B. Testing.* At our meeting on March 18 the commission considered the request of the Board of Trustees that we recommend standards for pre-school tuberculin testing, whether multiple puncture or Mantoux be used. No background information was given us at that time, and the six members present voted unanimously for Mantoux testing with the new stabilized solution of PPD(t).

Before our June meeting we received a letter from Dr. Roland Miller of Lafayette on Tine versus Mantoux testing, and we invited him to come to that meeting. A representative of the State Board of Health was invited too but was unable to attend. Dr. Miller reviewed the feelings of the Indiana Academy of Pediatrics, the law, certain information on the Tine test and suggested that the State Board of Health directive requiring the Mantoux test was restrictive of medical decisions. Dr. A. C. Offutt felt the purpose of the law was to screen, not diagnose the pre-school children. The commission agreed that the Mantoux test was the standard diagnostic test. Finally, the commission made the following recommendation to the Indiana State Board of Trustees: That the State Board of Health be requested to amend its present regulation HT6R, requiring Mantoux testing of pre-school children. The amendment should permit any physician holding an unlimited license to practice medicine and surgery in Indiana to choose that intradermal test which, in the exercise of prudent medical judgment, will satisfy the amendment to the 1967 act. The commission then thought that the above recommendations called naturally for another, to the effect that the State Board of Health initiate a program of professional education in intradermal skin testing, including management of positive reactors.

9. *Regionalization of Health Departments.* Throughout the year, the commission has inquired and received reports at each meeting on the status of the plan initiated a year ago on the above subject. The plan is in process of consideration by involved groups. Thorough documentation and supportive data is necessary before any approach is made for legislative action.

JAMES JOHNSON, M.D.,  
*Chairman*

ARNOLD BROCKMOLE, M.D.  
EDGAR CANTWELL, M.D.  
GORDON GUTMAN, M.D.  
WILLIAM B. SIGMUND, M.D.  
FRANCIS B. WARRICK, M.D.  
BYRON L. STEGER, M.D.  
BRUCE A. WORK, M.D.  
HERSCHEL BORNSTEIN, M.D.  
WILLIAM K. NEWCOMB, M.D.  
WARREN NICCUM, M.D.  
RAYMOND E. NELSON, M.D.  
ANDREW C. OFFUTT, M.D.  
JAMES HAWK, M.D.  
HUBERT GOODMAN, M.D.  
NOEL L. NEIFERT, M.D.  
MRS. EDESEL REED

## Public Information

The commission met four times during the year to consider the business of the commission.

Plans were completed to utilize a detailed but simplified questionnaire for members of the Association to learn more about their activities. It was the plan of the commission to mail this form with the dues requests and then compile the data on the cards for utilization by the State Medical Association in its various activities with the profession and the public. At the time of writing this report, full approval of the utilization of the form had not yet been given by the Board of Trustees of the Association.

Also, during the year "The Physician's Liability in Patient Care" was completed and was published in the June issue of THE JOURNAL of ISMA with a special feature cover announcement as to the value of this booklet as a ready desk reference for ISMA members.

Tel-Med came into operation during the year and, through the Commission on Public Information, various forms of publicity were given this new health information service, resulting in thousands of telephone calls from throughout the central Indiana area. The commission feels that the program is an extremely valuable one in terms of public relations and reflects the desires of a number of other physician-members of the Association to extend the program throughout Indiana.

During the year the commission initiated circulation of the waiting room bulletin, question-and-answer type poster. Efforts are being made to encourage more participation in the utilization of this bulletin, which emphasizes in brief question-and-answer style health infor-



mation, socio-medical-economic facts and medical organization philosophy and policy.

The commission also made selections in its annual journalism awards and its Physician Community Service Award of the Year. These awards annually attract more media participation and more physician interest.

The commission also gave serious consideration to the development of a special program which will utilize lay speakers representing the Association to lay organizations throughout the state. It was pointed out that such efforts by other organizations and corporations had proved effective and the commission will submit a format for the program and a budget to the Board of Trustees of the Association and to the House of Delegates with the hope that monies can be found to place this specialized speakers' bureau in effect during 1974. The estimated cost of such a bureau would run somewhere between \$15,000-\$20,000.

It was felt that the wide range of publicity received from local news media on such visitations and a total effect of intelligent and factual reports to people through the medium of their local community meetings should, over a period of time, have extraordinary effects on individual understanding of many of the positions which physicians take in politics and on socioeconomic matters.

One of the major problems during the year was the television show which was aired by NBC and which contained false facts relative to medical care costs. A letter which was written by Dr. Ernest Howard, AMA executive, to the NBC president, Mr. Julian Goodman, contained an abundance of facts which rebutted the erroneous statements and which could be utilized in the new speakers' bureau program. The commission agrees that it is imperative that this type of information be more widely disseminated. An effective professional speakers' bureau could do much to dispel such blatantly incorrect statements.

The commission monitored the distribution of two leaflets—one entitled "Medicare Misconceptions" and the other "As a Medicaid Patient." They made known the fact that over 150,000 of these two leaflets were distributed to doctors throughout Indiana. The leaflets were, in essence, an effort to tell the patient the extent and limitations in both the Medicare and Medicaid programs. Physicians utilizing them found them worthwhile.

As an outgrowth of this distribution, the commission turned its thoughts to the development of a similar leaflet on

health insurance problems which could be distributed to the lay public for their information and their additional understanding of the insurance industry and the physician's role in the total picture. Consideration is also being given to the development of a professional publication for members of the state society to provide them with more substantial information upon varying insurance programs.

Another new concept involving more direct contact with the media was initiated during the year. It will be the commission's endeavor over the next few months to develop a system whereby material channeled through the ISMA office can, in turn, be channeled to physicians who are close to editors and publishers and other high-level individuals in the media industry throughout Indiana. The system has worked effectively in other areas, especially with the Legislative Commission. Efforts are now being made to gather information on physicians and editors in order to effectively institute the procedure.

The commission also reviewed a special Blue Cross—Blue Shield venereal disease leaflet and made recommendations and suggestions concerning the dissemination of the material throughout the state.

DAVID G. CRANE, M.D.,

*Chairman*

WILLIAM B. CHALLMAN, M.D.

THOMAS O. MIDDLETON, M.D.

LOUIS H. BLESSINGER, M.D.

KENNETH D. SCHNEIDER, M.D.

RICHARD S. BLOOMER, M.D.

HARRY T. HENSLEY, M.D.

THOMAS A. HANNA, M.D.

PAUL BURNS, M.D.

KENNETH J. AHLER, M.D.

JOHN A. FORCHETTI, M.D.

EUGENE T. KARNAFEL, M.D.

FRED DAHLING, M.D.

BARBARA BACKER, M.D.

HARRY G. BECKER, M.D.

VICTOR JOHNSON, M.D.

ROBERT W. HARGER, M.D.

MRS. STANLEY CHERNISH

## Special Activities

The Commission on Special Activities met on December 10, 1972, February 18, April 1, and May 6, 1973. The Commission's Subcommittee on Rural Health, chaired by Richard D. Hawkins, M.D., met on February 18, April 1, May 6, and July 8, 1973.

In addition to the Commission's regular members, the meetings of the Commission and of the Subcommittee on Rural Health were attended by several

guests and consultants who actively participated in the work of the Commission. These included the ISMA president, James H. Gosman, M.D., William M. Sholty, M.D., Norman Beaver, M.D., Robert Acher, M.D., Mrs. Sarah Ackerson, Mr. Len Bastian, Mr. Marlin Gray, preceptee of Dr. Ellis, and ISMA staff

The Commission was particularly pleased with the help it received from a number of Indiana University medical students, Robert C. Kaye, Greg Larkin, John C. Johnson and Patrick McAleavey.

The Commission reviewed existing programs that provide financial aid to medical students wishing and/or willing to practice medicine in rural areas. Particular attention was paid to the Rural Kentucky Medical Scholarship Fund as a possible model to be adopted in Indiana. From information gathered, the Commission concluded that forgiveness loans were not popular with medical students and that loan forgiveness plans have not been successful in eleven states. The Commission advised against adoption of such a plan in Indiana.

The Commission reviewed and approved a request from John C. Johnson, a senior medical student and president of Student Council, I.U. School of Medicine, to use the ISMA mailing list to distribute a letter and questionnaire designed to gather data on the physician shortage in Indiana. His subsequently completed study, for which Mr. Johnson was formally commended, was accepted for publication in the *ISMA Journal* and formed the basis for a discussion at a Student-Doctor-Faculty Retreat in Brown County. Mr. John C. Johnson's report and the Retreat generated stimulating ideas which the ISMA Executive Committee referred to the Subcommittee on Rural Health. The Subcommittee has established a temporary Assessment Committee which is preparing a report and recommendations.

Dr. Raymond H. Murray, Director of Regenstrief Institute and Chairman, Department of Community Health Sciences, I.U. School of Medicine, and Mrs. Sarah Ackerson presented the results of a study on the delivery of health care in rural areas. The report, which is being prepared for publication, has provided additional valuable information to the Commission in discussions of health manpower in rural and small town Indiana.

Dr. Richard D. Hawkins attended the AMA Rural Health Conference in Dallas on March 29 and 30, 1973, and reported back the following findings to the



## Commission:

1. Physicians who are born in rural areas tend to return to rural areas to practice.
2. Physicians have a tendency to practice within 150 miles of where they took their post graduate training.
3. Group practice country-wide has been a tool that has induced a flow of physicians to rural areas.
4. Reasons for doctors either not going to rural areas or leaving rural areas include overwork, lack of continuing education, attitude of wife, lack of cultural opportunities, downgrading of the local M.D. by staffs of medical schools in general, lack of coverage when out of town, lack of a foreseen replacement, and lack of ready consultation.
5. The reasons for practioners choosing group practice in rural areas include predictable hours, ready consultation and diminution of business management by the individual physician.

The Commission passed the following three resolutions:

1. Whereas, the percentage of family practioners in the State of Indiana is declining while the percentage of medical specialties is increasing, and  
Whereas, there is an urgent need of more family practitioners, and  
Whereas, more medical students have expressed an interest in family practice training, and  
Whereas, the facilities for training family practitioners are markedly limited owing to a shortage of funds and other resources,  
Now, Therefore Be It Resolved by this Commission on Special Activities of the Indiana State Medical Association that medical educational institutions in the state of Indiana increase their support for family practice residencies and other family practice training programs even if this should result in a reduction in current support for training in other specialties.
2. Inasmuch as the family physician has been decreasing in population, yet the current students in medical training evidence a greater interest in family practice over other specialties,  
Be It Resolved, that the Council on Medical Education be directed to review the number of available residencies in family practice in rela-

tion to other specialties and to consider increasing the number of available residencies in family practice and decreasing those in the specialty fields that are overly represented.

3. Be It Resolved that greater utilization be made of community hospitals, outpatient facilities, and medical practitioners in the support of family practice training programs.

## COMMISSION ON SPECIAL ACTIVITIES

HANUS J. GROSZ, M.D., *Chairman*  
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WILLIAM H. GARNER, JR., M.D.  
JOHN C. LINSON, M.D.  
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JOSE S. CABIGAS, M.D.  
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GEORGE WAGONER, M.D.  
NORMAN BEAVER, M.D.  
THOMAS J. QUILTY, M.D.  
PETER E. GUTIERREZ, M.D.  
ROBERT P. ACHER, M.D.  
DWIGHT W. SCHUSTER, M.D.  
MRS. JAMES GUTHRIE

## SUBCOMMITTEE ON RURAL HEALTH

RICHARD D. HAWKINS, M.D.,  
*Chairman*  
JAMES H. GOSMAN, M.D.  
GEORGE M. ELLIS, M.D.  
ELI GOODMAN, M.D.  
DONALD HUNSBERGER, M.D.  
JOHN C. LINSON, M.D.  
HANUS GROSZ, M.D.  
A. ALAN FISCHER, M.D.  
RAYMOND H. MURRAY, M.D.  
PETER E. GUTIERREZ, M.D.  
ROBERT C. KAYE  
GREG LARKIN

## Voluntary Health Agencies

The commission met four times during the year to conduct its business relating to Indiana's voluntary health agencies.

Approval was given to the following agencies which submitted comprehensive reports to the commission concerning their programs and activities:

Indiana Division, American Cancer Society, Inc.  
The Arthritis Foundation, Indiana Chapter  
Indiana Association for Retarded Children

Hemophilia of Indiana, Inc.  
Indiana Easter Seal Society for Crippled Children and Adults, Inc.  
Indiana Heart Association, Inc.  
Indiana Society for the Prevention of Blindness  
Kidney Foundation of Indiana  
Mental Health Association in Indiana, Inc.  
United Cerebral Palsy of Indiana, Inc.  
Indiana Lung Association  
Tri-State Epilepsy Association, Inc.  
Indiana Chapter, National Multiple Sclerosis Society  
Indiana Committee to Combat Huntington's Disease

The Commission was saddened by the untimely death of its chairman, Dr. Norman R. Booher, who had directed the activities of the Commission for many years with enthusiasm and innovative ideas. His leadership and dedication to the commission and to organized medicine will be sorely missed.

In keeping with his foresight and energies, the tasks for the commission had been planned to a point by Dr. Booher permitting the commission's business to continue smoothly and without interruption, which in itself speaks for Dr. Booher's commitment.

During the year, members of the Woman's Auxiliary to the Indiana State Medical Association became involved in the commission's activities, naming representatives from each of the 13 ISMA districts and two members at large to complement the organization of the commission.

These representatives were appointed to liaison positions with the agencies along with the commission members and served by attending meetings of the agencies and becoming informed on agency activities.

Mrs. Jack Walker of Yorktown served as chairman of the women's group through appointment to that position by the president of the Auxiliary, Mrs. Philip L. Smith, Fort Wayne.

Addition of the Auxiliary group in the activities of the commission gave an added dimension to the commission's activities and was received with great appreciation by the agency executives and officers.

Dr. Booher, who had been a member of the American Medical Association Council on Voluntary Health Agencies, advised the commission that the Board of Trustees of the AMA and a follow-up action of the House of Delegates of the AMA had abolished this particular



council in the interest of economy. He pointed out he had discussed the entire matter with Dr. Gosman, president of ISMA, who advised him that not only should the ISMA Commission on Voluntary Health Agencies stay active but should strengthen and broaden its activities in Indiana. Dr. Booher commented that a survey of Indiana voluntary agencies revealed that there are roughly 500,000 lay volunteers participating, which offers a tremendous base for providing information on the activities of the commission and organized medicine in Indiana.

The Commission on Convention Arrangements was advised by the Commission on Voluntary Health Agencies on the availability of speakers from the agencies. The agencies, through the commission, had expressed an interest in assisting the convention group in this capacity. The objective of the recommendation was to insure greater economies in the operation of the convention while at the same time maintaining the acquisition of top quality medical speakers for the event.

With the activation of the Tel-Med telephone library and the utilization of some 100 discussions on health topics, the voluntary health agencies expressed interest in participating in the program by offering additional tapes in their particular health areas. The commission feels that a cooperative agreement should be instituted with the approved agencies to add to the library and to further this successful public service.

The commission also printed and distributed the placard identifying agencies that were approved for 1973. Some 10,000 of these placards are distributed annually by the commission and the agencies for the information of the public. The commission feels that this is a worthwhile public service since it does give the citizens of Indiana an opportunity to know of the many excellent agencies which meet the rather stringent criteria for approval and can help them in directing their personal support, since the backbone of agency operation is voluntarism.

The commission also held during the year its annual meeting with executives, officers and board members of the agencies. Some 75 members of the commission, the Auxiliary, and the agencies were in attendance. The meeting is held to exchange information and ideas on continued cooperation and development of programs between the groups. Suggested participation in Tel-Med was one

of the outgrowths of this year's meeting.

At the suggestion of the agencies, the commission this year instituted extending invitations to selected agency representatives to attend regular meetings of the commission and to participate in the deliberations of the commission.

The commission worked in cooperation with the Commission on Public Information in requesting consultation on methods of publicizing the activities of the commission.

The Commission on Public Information recommended that the Commission on Voluntary Health Agencies develop a book styled in the format of the American Medical Association's booklet on national voluntary health agencies, with the distribution of the booklet (which would basically outline the purposes and services of the agencies) coordinated through the Commission on Public Information.

The commission recommends that this be one of the projects for the 1973-1974 Commission on Voluntary Health Agencies.

NORMAN R. BOOHER, M.D.

*Chairman (Deceased)*

E. DE VERRE GOURIEUX, M.D.

ROBERT H. RANG, M.D.

T. A. NEATHAMER, M.D.

WAYNE CROCKETT, M.D.

DONN R. HUNTER, M.D.

LOWELL W. PAINTER, M.D.

WALFRED A. NELSON, M.D.

WENDELL W. AYRES, M.D.

FRANK J. MCGUE, M.D.

CHARLES RUSHMORE, M.D.

ALVIN T. STONE, M.D.

ROBERT W. BRIGGS, M.D.

*Woman's Auxiliary Liaison Members to Voluntary Health Agencies*

MRS. JACK WALKER,

*Chairman*

MRS. RALPH DREYER

MRS. A. W. RATCLIFFE

MRS. W. R. VAUGHN

MRS. JOHN PARIS

MRS. MICHAEL FREE

MRS. MILTON CALDWELL

MRS. JAMES GUTHRIE

MRS. H. R. WIREY

MRS. CARLSON SPECK

MRS. J. J. LIND

MRS. A. MAYORGA

MRS. EUGENE RIFNER

MRS. RONALD KLEOPFER

MRS. DAVID D. OAK

## Emergency Medical Services

The first meeting of the Commission on Emergency Medical Services was held January 7, 1973. Dr. Cleon Schauwecker was elected vice-chairman and Dr. Howard Williams, secretary. A Bill granting legislative status to paramedical personnel involved in Emergency Medical Care was discussed and was recommended to the Legislative Study Committee for action. The Commission also discussed the Emergency Medical Services Bill of 1973 and its possibilities for passage in the current Legislature.

In the next meeting of the Commission on March 18, 1973, the principal matter for discussion was the fate of the Indiana Emergency Medical Services Act of 1973. It was the Commission's feeling that the bill was being purposely watered down from a comprehensive program of Emergency Care to one involving only ambulance and technician training. The Commission also felt that there was an obvious trend to eliminate medical professionals from any part in planning the bill. As a result of these discussions, it was felt that the Indiana State Medical Association should spearhead an effort by "Health Professionals" to push for a comprehensive program and bill to be prepared for the 1974 Legislative Session. As a result of this discussion the group voted to establish an Indiana Emergency Medical Services Council, composed of health professionals including physician groups, nursing groups and the Hospital Association. Subsequently, letters were sent to representatives of the American College of Surgeons, the Indiana Academy of Family Practice, the American College of Emergency Physicians, the American College of Physicians, the Indiana State Nurses Association and the Indiana Hospital Association. These groups were invited to send representatives to an initial meeting which was subsequently held Wednesday, May 2, at the offices of the Indiana State Medical Association.

At this meeting, a long discussion of the problems confronting Emergency Medical Services in the state of Indiana was carried out. A committee was formed to establish basic standards of emergency medical care which would then be presented to the Governor as representing what the "Health Professionals" in the State of Indiana deemed necessary for their patients. These standards were very rapidly developed and were subsequently passed upon by the Boards of Directors of the various



agencies mentioned above; including the Indiana State Medical Association.

Another meeting of the Emergency Medical Services Council was held at the State Medical Headquarters on May 23, 1973. At that meeting some changes were made in the standards and a very interesting discussion of legislative mechanics was given the group by Dr. William Paynter, the new Commissioner of the Indiana State Board of Health. The entire group was quite happy with the sentiments of cooperation expressed by Dr. Paynter and greatly appreciated his sage advice on how to present this problem to the Legislature and to the Governor.

On May 25, 1973, a group including representatives of Indiana nursing organizations, the Indiana Hospital Association and the Indiana State Medical Association met with Governor Bowen. State Medical was represented by Mr. Waggener, Dr. Suelzer and Dr. Gosman. Governor Bowen expressed his feeling that Emergency Medical Service Legislation was of high priority and pledged the support of his administration for passage of such a Bill in the next

legislature. He also granted permission to call a one-day "Governor's Conference on Emergency Medical Services."

Subsequent to the meeting with Governor Bowen, a steering committee was established to plan the conference. At the point of time this report is written, the conference has been scheduled for July 23, 1973. It is to be held in the new Convention Center in downtown Indianapolis, with an anticipated attendance of approximately 500 people. Governor Bowen will give the opening address. The main purpose of the meeting will be to bring together all interested parties to discuss, revise and draft legislation for the upcoming session. It was felt by all of the "Health Professionals" that many people who to this point have opposed such legislation have done so out of ignorance of its purpose and of the enormity of its restrictions. It was felt that just by getting a large number of these people together to discuss the problem we could dispel many of the problems.

The chairman of the Commission on Emergency Medical Services wishes spe-

cifically to thank certain members of the Commission for their regular attendance at meetings and for their support and interest in the projects of the Commission; Drs. Schauwecker, Williams, Gossom, Babb, Farquhar and Graber. The attendance and interest of Mrs. Phillip L. Smith, president of the Woman's Auxiliary to the Indiana State Medical Association is also appreciated.

JOHN G. SUELZER, M.D.  
*Chairman*

RAYMOND W. NICHOLSON, M.D.  
GEORGE N. LEWIS, M.D.  
CHARLES B. CARTY, M.D.  
HENRY SCHIRMER RILEY, M.D.  
DONN R. GOSSOM, M.D.  
WILLIAM F. KERRIGAN, M.D.  
HOWARD WILLIAMS, M.D.  
DAVID J. DIETZ, M.D.  
FORREST J. BABB, M.D.  
WILLIAM NOWLIN, M.D.  
THOMAS R. SCHERSCHEL, M.D.  
JOHN S. FARQUHAR, JR., M.D.  
JAMES D. FINFROCK, M.D.  
CLEON SCHAUWECKER, M.D.  
MARTIN J. GRABER, M.D.  
MRS. PHILIP L. SMITH



# Resolutions

## Amendments to the Constitution to Be Voted on at Indianapolis Session 1973

At the 1972 annual convention at Indianapolis, the House of Delegates adopted the report of the Reference Committee in which the Reference Committee recommended for adoption the following amendments to the Constitution.

In addition, the House of Delegates adopted Resolution No. 72-20, calling for the creation of the offices of Speaker and Vice-Speaker. The text of that amendment along with three additional technical changes necessitated by the amendment are also included and are eligible for final action during the 1973 annual convention.

### Article IV, Section 1, Composition of the Association

Be It Resolved that Article IV, Section 1, be amended by striking the entire Section 1 as now printed and substituting the following:

Section 1. This Association shall consist of Active Members, Associate Members, Senior Members, Honorary Members, Disabled Members and Distinguished Members.

### Article IV, Section 3, Composition of the Association

Be It Resolved that Article IV, Section 3, be amended by inserting a period after the word "Association" and striking the balance of the sentence. Section 3 will then read:

Section 3. Interns and Residents. Interns and Residents who hold membership in the Indiana State Medical Association shall have all the rights and privileges of this Association.

### Article IV, Section 5, Composition of the Association

Be It Resolved that Section 5 of Article IV of the Constitution be amended by striking the entire Section 5 as now printed and substituting the following:

Section 5. Senior Members. Senior Members shall be physicians of the state of Indiana who have attained the age of 70 years and have held membership in the Indiana State Medical Association for 20 years or more; or who have held membership in the Indiana State Medical Association or in some one or more other like state organization which is a component state organization of the American Medical Association, for a combined

total of 20 years or more, and who, upon their application, have been certified to the Executive Secretary as eligible for such membership by the county societies of which they are members. It shall be the duty of the county medical society to verify, through the office or offices of any other state organization or organizations, the fact of membership therein when such membership is claimed as part compliance with the eligibility requirement of 20 years of membership.

### Article IV, Section 7, Composition of the Association

Be It Resolved that Article IV, Section 7, be renumbered as Section 8 and a new Section 7 be substituted to read as follows:

Section 7. Distinguished Members. Active Members who have fulfilled the American Medical Association's Physician Recognition Award requirements of 150 hours for three years of continuing medical education as a minimum shall be designated as Distinguished Members.

(Old Section 8 be renumbered Section 9)

### Article V, House of Delegates

Be It Resolved that Article V be amended to read as follows:

Section 1. The House of Delegates shall be the legislative and business body of the Association and shall consist of (1) delegates, or their designated alternates, elected by the component county societies; (2) the Trustees, or their designated alternates, (3) the ex-presidents of the Indiana State Medical Association, and (4) delegate or their designated alternate delegate elected by their respective Section. The following shall be ex officio members: the President, the President-elect, the Executive Secretary, the Treasurer and Assistant Treasurer of this Association, the Speaker, the Vice Speaker, and the delegates to the American Medical Association, all without power to vote, except in case of a tie, when the person presiding shall cast the deciding vote.

Section 2. The Speaker of the House of Delegates shall preside at all meetings. He shall be elected annually from the membership of the House. Ex Officio, the Speaker shall be a member of all Commissions and Committees and the Board of Trustees of this Association without the power to vote. Training in parliamentary procedure shall be mandatory for the Speaker and shall be provided at the expense

of the Association.

Section 3. The Vice-Speaker of the House of Delegates shall preside at meetings in the absence of the Speaker or at the request of the Speaker. The Vice-Speaker shall be elected annually from the membership of the House. Ex Officio, he shall be a member of all Commissions and Committees and the Board of Trustees of this Association without the power to vote. Training in parliamentary procedure shall be mandatory for the Vice-Speaker and shall be provided at the expense of the Association. In the event the Speaker dies or resigns while in office, the Vice-Speaker shall assume the role of Speaker for the unexpired term.

Section 4. All sessions of the House of Delegates shall be open to all members in good standing of this Association for observation.

### Article VI, Board of Trustees

Be It Resolved that Article VI be amended by adding the words "Immediate past president" following the word "Treasurer," and also by striking the word "and" after the word "vote" and before the word "assistant" and inserting a comma in lieu thereof, and by striking the period after the word "absent" and substituting the following: ", and the speaker and vice-speaker without power to vote." Article VI would then read as follows:

The Board of Trustees shall consist of (1) the trustees with power to vote and their duly elected alternates, each of the latter without power to vote except in the absence of his Trustee; and (2) ex officio, the president, president-elect, treasurer, immediate past president with power to vote, assistant treasurer without power to vote except in case the treasurer be absent, and the speaker and vice-speaker without power to vote. Besides its duties mentioned in the Bylaws, the Board of Trustees shall have full charge and control of all property of the Association. It shall have full authority and power of the House of Delegates between sessions of the House of Delegates, except that it shall not make changes in the laws governing the Association nor exercise legislative functions, except as stated in the Bylaws, and at all times shall be the finance committee of the Association. A majority of elected trustees shall constitute a quorum.

### Article IX, Section 1, Officers

In line with the above-proposed amendment, it would also be necessary



to amend Article IX, Section 1, of the Constitution, by inserting after the word "President-elect" and before the word "an" the words "the immediate past president," and also by inserting the words, "A Speaker, a Vice-Speaker" after the words "assistant treasurer." Article IX, Section 1, would then read as follows:

Section 1. The officers of this Association shall be a president, a president-elect, the immediate past president, an executive secretary, a treasurer, an assistant treasurer, a speaker, a vice-speaker, and the trustees, each of whom shall be a member, except the executive secretary, who need not necessarily be either a physician or a member.

Resolution No. 73-1

**Introduced by:** Clark County Medical Society  
**Subject:** REDECLARATION OF NON-PARTICIPATION POLICY  
**Referred to** Reference Committee No. 5  
(William G. Bannon, M.D., Chairman)

Whereas, The free enterprise, fee-for-service system of medical practice in the United States makes most efficient use of available medical personnel, encourages high quality medical care, and preserves the freedom of patient and doctor; and

Whereas, Government intervention between the practicing physician and the patient historically removes responsibility from both parties and leads to decrease in quality of medical care; and

Whereas, The provisions of PSRO would sharply interfere with the nature of the doctor-patient relationship and lead to a poorer rather than a better health care standard in this country; now, therefore, be it

Resolved, That the Clark County Medical Society urge the Indiana State Medical Association to notify the Department of Health, Education, and Welfare that its membership will be encouraged to not participate in PSRO-type activities.

Resolution No. 73-2

**Introduced by:** Clark County Medical Society  
**Subject:** PREVENTION OF ADVERTISING IN MEDIA BY ALL SO-

CALLED MEMBERS OF THE HEALING ARTS  
**Referred to:** Reference Committee No. 5  
(William G. Bannon, M.D., Chairman)

Whereas, Chiropractic advertisements appear rather regularly in various newspapers in the state of Indiana implying that chiropractors can treat most any medical disorder or problem with chiropractic adjustments; and

Whereas, The Chiropractor is obviously, therefore, advertising for the practice of medicine; and

Whereas, The licensing of physicians in the practice of medicine is tightly controlled by law while a chiropractor with no medical training can actually advertise for the practice of medicine; and

Whereas, It is the position of the medical profession that chiropractic is an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease; and

Whereas, Chiropractic constitutes a hazard to rational health care because of the substandard and unscientific education of its practitioners and their rigid adherence to an irrational, unscientific approach to disease causation; and

Whereas, Advertising by physicians, dentists or other members of the so-called healing arts is considered unethical and does not occur; and

Whereas, Indiana citizens should not have to be exposed to chiropractic advertising which is often misleading and untrue; and

Whereas, At present there is nothing in the Indiana law that prevents advertising by a chiropractor; now, therefore, be it

Resolved, That the Clark County Medical Society recommends that the Indiana State Medical Association take all necessary steps to encourage the formulation and passage of appropriate action by the Legislature of the State of Indiana to prevent advertising in the media by all so-called members of the healing arts.

Resolution No. 73-3

**Introduced by:** Marion County Medical Society  
**Subject:** ESTABLISHMENT OF AN ISMA SECTION ON ALLERGY

**Referred to:** Reference Committee No. 2  
(Robert P. Acher, M.D., Chairman)

Whereas, There is an extreme shortage of well-trained allergists to care for the allergic patient load in the state of Indiana; and

Whereas, The medical schools in every state surrounding Indiana have departments of allergy and allergy resident training programs and the Indiana University School of Medicine does not; and

Whereas, Establishment of a Section on Allergy in the Indiana State Medical Association would be instrumental in furthering the development of a Department of Allergy at the Indiana University School of Medicine; and

Whereas, Programs can be developed on a postgraduate level to help further the education of doctors already in practice concerning allergies; and

Whereas, The Section on Allergy also could participate in programs at the annual meeting of the Indiana State Medical Association, offering papers of current interest to those practicing general medicine and special programs for those who limit their practice to allergy; and

Whereas, The annual meeting of the Indiana State Allergy Society could be held during the annual meeting of the Indiana State Medical Association, thus increasing attendance and participation in both meetings; therefore, be it

Resolved, That the Indiana State Medical Association establish a Section on Allergy.

Resolution No. 73-4

**Introduced by:** Future Planning Committee  
**Subject:** SPECIAL REFERENCE COMMITTEE  
**Referred to:** Reference Committee No. 3  
(Albert M. Donato, M.D., Chairman)

Whereas, The Special Reference Committee of the 1972 annual meeting heard extensive, valuable testimony; and

Whereas, This is an opportunity for all members of the Indiana State Medical Association to make their views known to the officers, to the House, and to the Board of Trustees; and

Whereas, The attendance at this Special Reference Committee was extremely large, and enthusiastic; now, therefore, be it

Resolved, That a Special Committee,



open to all members of ISMA, be held in conjunction with the annual meeting at every other year, on the even numbered year, to provide information not otherwise obtainable by the officers, the Board of Trustees and the House of Delegates.

### Resolution No. 73-5

**Introduced by:** Commission on Medical Education & Licensure  
**Subject:** ADDITIONAL ISMA STAFF MEMBERS  
**Referred to:** Reference Committee No. 4  
(Ross L. Egger, M.D., Chairman)

Whereas, The ISMA House of Delegates has approved an ISMA continuing medical education accreditation system and a CME award on the recommendation of the Commission on Medical Education and Licensure; and

Whereas, There is a large amount of additional work required to carry on the system; and

Whereas, The present ISMA staff will be unable to handle the additional work load; now, therefore, be it

Resolved, That the House of Delegates authorize the employment of a director, with necessary staff, to head an office for continuing medical education. (Attached fiscal note)

Fiscal Note—estimated cost per year \$50,000. Salary of director, secretarial work and office equipment.

### Resolution No. 73-6

**Introduced by:** Commission on Medical Education and Licensure  
**Subject:** CHANGE IN THE CONSTITUTION AND BYLAWS TO PROVIDE FOR:

- (a) ADDITIONAL FUNCTIONS OF THE COMMISSION ON MEDICAL EDUCATION AND LICENSURE AND
- (b) PROVISION FOR A STANDING COMMITTEE ON CONTINUING MEDICAL EDUCATION

**Referred to:** Reference Committee No. 2  
(Robert P. Acher, M.D., Chairman)

Whereas, The ISMA at its annual meeting in October 1972, adopted the recommendations of the Commission on Medical Education and Licensure to encourage its members to participate in approved continuing medical education programs by providing a special membership category and presenting an ISMA award seal to be attached to the American Medical Association's Physician Recognition Award Certificate for members complying with the AMA continuing medical education requirements; and

Whereas, The ISMA has approved an accreditation system for local and intrastate continuing medical education programs; and

Whereas, A subcommittee of the Commission on Medical Education and Licensure was appointed to carry out the planning and development of procedures to implement these activities for the commission; and

Whereas, Both accreditation and award procedures will be an expanding and ongoing and more important function of the ISMA through its Commission on Medical Education and Licensure; and

Whereas, The Constitution and Bylaws do not provide for these functions or for a standing committee for this purpose; now, therefore, be it

Resolved, That the Constitution and Bylaws be revised to provide for a new standing committee (to replace the Subcommittee on Accreditation) to be called the Committee on Continuing Medical Education, and that it be further

Resolved, that Chapter VIII.—Organization of Activities and Responsibilities—Section 1—have added to it the name of the new committee—Committee on Continuing Medical Education; and that it be further

Resolved, that Chapter XXIII.—Commission on Medical Education and Licensure—be revised by the supplement of two sections (Nos. 2 and 3) in the following manner to include the additional functions of the commission:

Section 1.—Unchanged.

Section 2.—The commission shall, based upon information and recommendations from the Committee on Continuing Medical Education, accredit institutions and organizations providing local or intrastate continuing medical education programs.

Section 3.—The commission shall, based upon information and recommendations from the Committee on Continuing Medical Education, award the

ISMA Seal to be attached to the AMA-PRA certificate for physicians completing their CME requirements. It will also designate ISMA member-recipients as 'Distinguished Members'; and be it further

Resolved, That a new chapter be added (Example, Chapter XXX) and entitled: "Chapter .—Committee on Continuing Medical Education," with the following sections:

Section 1.—In order to assure continuity, the chairman of the Commission on Medical Education and Licensure will annually review membership and make appointments, where necessary. The Committee on Continuing Medical Education shall be composed of:

- (a) The chairman
- (b) The representatives from the specialty societies (13 maximum)
- (c) One representative from AIDME
- (d) Five representatives from the ISMA Commission on Medical Education and Licensure

Section 2.—The Committee on Continuing Medical Education shall meet at least quarterly and shall be a consulting and reviewing body for institutions and organizations seeking accreditation of local intrastate CME programs. In addition to consulting with and advising such institutions and organizations, it will make recommendations to the Commission on Medical Education and Licensure regarding accreditation.

Section 3.—The Committee on Continuing Medical Education shall establish and maintain mechanisms and systems of review and evaluation and documentation with identification of ISMA members completing the prescribed CME requirements and shall recommend to the Commission on Medical Education and Licensure the recognition of these members.

(With the above-mentioned instituted changes, the following chapters of the ISMA Constitution and Bylaws will be renumbered as appropriate.)

### Resolution No. 73-7

**Introduced by:** Commission on Medical Education & Licensure  
**Subject:** HOUSE STAFF MEMBERSHIP  
**Referred to:** Reference Committee No. 2  
(Robert P. Acher, M.D., Chairman)

Whereas, The ISMA is encouraging house staff officer participation in the ISMA; and



Whereas, The ISMA needs to develop programs devoted to house staff concern and needs house staff input; now, therefore be it

Resolved, That the house staff be encouraged to join both county society and ISMA at a reduced rate; and be it further

Resolved, That the membership be a full membership with all privileges to vote and hold office; and be it further

Resolved, That such county membership be in the county of origin for state residents and in the county of training for out-of-state residents.

## Resolution No. 73-8

**Introduced by:** Commission on Medical Education & Licensure  
**Subject:** ANNUAL MEETING  
EDUCATIONAL PROGRAM

**Referred to:** Reference Committee  
No. 4  
(Ross L. Egger, M.D.,  
Chairman)

Whereas, The Commission on Medical Education and Licensure has a definite interest in and responsibility for the educational activities of ISMA; and

Whereas, No formal arrangements have been made for the commission to participate in planning the educational activities of the annual meeting of the ISMA; now, therefore, be it

Resolved, That in the future there be at least one joint meeting annually of the Commission on Medical Education and Licensure with the Commission on Convention Arrangements for the purpose of helping plan the educational activities for the annual ISMA convention.

## Resolution No. 73-9

**Introduced by:** Tippecanoe County Medical Society

**Subject:** DRUG ABUSE

**Referred to:** Reference Committee  
No. 5  
William G. Bannon,  
M.D., Chairman

Whereas, The rising problem of drug abuse, especially narcotics, is of increasing concern to all Americans and especially to physicians; and

Whereas, The United States government with state and local help has established many programs to combat this problem; and

Whereas, President Nixon expresses our government's leadership in combating

the criminal drug trade stating, "Any government whose leaders participate in or protect the activities of those who contribute to our drug problem should know . . . Our goal is unconditional surrender of the merchants of death who traffic in heroin"; and

Whereas, Red China has and is producing, refining, and exporting heroin as a cash crop, estimated to be well over half the world's illegal supply. That this is the official governmental policy of Red China, has been confirmed by our narcotics officials and those of the Republic of China (Taiwan), Great Britain, Holland, and France; and

Whereas, Red China, in addition to other forms of smuggling, uses diplomatic and commercial attaches in other countries to carry out this illicit trade; and

Whereas, The Red Chinese are making arrangements to set up their first liaison office in Washington, D.C., to facilitate relations between the United States and Red China; and

Whereas, As physicians we must oppose any actions detrimental to the health and well being of our patients and oppose any activities which would increase the dangers of greater narcotic traffic; therefore, be it

Resolved, That we, the members of the Tippecanoe County Medical Society, respectfully request President Nixon to specify as one of the conditions for establishing such liaison offices that Red China join with other nations in combating rather than promoting the narcotics traffic; and, be it further

Resolved, That a letter to this effect be sent to President Nixon, Senators Hartke and Bayh, and Representative Earl Landgrebe; and, be it further

Resolved, That a copy of this resolution be sent to the Indiana State Medical Association for its approval.

## Resolution No. 73-10

**Introduced by:** Vanderburgh County  
**Subject:** LEGISLATION TO  
DEFINE THE WORD  
"PHYSICIAN"

**Referred to:** Reference Committee  
No. 5  
William G. Bannon,  
M.D., Chairman

Whereas, Indiana courts have construed the word "physician" to include a person in the practice of chiropractic; and

Whereas, The term "physician" is ordinarily understood by laymen to signify persons who are graduates of

schools of medicine or schools of osteopathy; and

Whereas, The application of this term to graduates of schools of chiropractic is misleading as to both the amount and the quality of education of the practitioner; and

Whereas, The validity of the foregoing statements has been recognized by a formal endorsement of the Indiana State Medical Association House of Delegates in annual convention in October 1972; and

Whereas, The staff of the Indiana State Medical Association did subsequently seek to encourage members of the Indiana State Legislature to redefine the legal meaning of the term "physician" through support of appropriate legislation; now, therefore, be it

Resolved, That the Indiana State Medical Association again prepare and seek to have introduced into the General Assembly a bill defining the term "physician" as applying only to persons holding the academic degree of Doctor of Medicine, or Doctor of Osteopathy.

## Resolution No. 73-11

**Introduced by:** Fort Wayne-Allen  
County Medical Society  
**Subject:** HOUSE OF  
DELEGATES  
MEETING(S)

**Referred to:** Reference Committee  
No. 1  
(Thomas C. Tyrrell,  
M.D., Chairman)

Whereas, A significant portion of the business conducted during the meeting of the House of Delegates relates to and is important to the design of state legislation;

Whereas, The input to legislative committees has its maximum relative impact in the summer months prior to the convening of Legislature; and

Whereas, The Indiana State Medical Association meets in the fall, making House of Delegates' recommendations incident upon the legislative committees after most of their work is complete; now, therefore, be it

Resolved, By the House of Delegates of the Indiana State Medical Association that:

1. If one meeting of the House of Delegates is held in any calendar year, that the meeting date will be between the 1st of April and the 15th of May.
2. If two meetings are held, that only one meeting will be accompanied by a scientific session, and that the



dates of the meetings be as follows: one between April 1st and May 15th, and the second between October 1st and November 15th.

### Resolution No. 73-12

**Introduced by:** Fort Wayne-Allen  
County Medical Society  
**Subject:** FISCAL  
RESPONSIBILITY  
**Referred to:** Reference Committee  
No. 3  
(Albert M. Donato,  
M.D., Chairman)

Whereas, Fiscal responsibility is required of all viable organizations; and

Whereas, Evidence of such responsibility should be furnished to the membership of such organizations; now therefore, be it

Resolved, That a full breakdown of monies expended to individual members of the Indiana State Medical Association who act in an official capacity in and for the Association be added to the annual financial report appearing in *The Journal* of the Indiana State Medical Association.

### Resolution No. 73-13

**Introduced by:** Fort Wayne-Allen  
County Medical Society  
**Subject:** PRESCRIPTION  
LABELING  
**Referred to:** Reference Committee  
No. 3  
(Albert M. Donato,  
M.D., Chairman)

Whereas, Accidental poisoning of children and drug overdose by adults of prescription drug items is an all-too-common occurrence in this state; and

Whereas, The treatment of this problem frequently is undertaken at hours when information concerning the exact nature and strength of the drug involved is difficult to obtain either from the pharmacist and/or physician; and

Whereas, This problem is the rightful concern of every physician and pharmacist practicing in this state; now therefore, be it

Resolved, That the Board of Trustees of the Indiana State Medical Association strongly recommend to the governing body of the Indiana Pharmaceutical Association and its membership that a statewide program be initiated to cause the printing of the name, strength, and amount dispensed of the prescription drug on the label of every prescription filled, unless stated to the contrary in writing by the prescribing physician.

### Resolution No. 73-14

**Introduced by:** Commission on Aging  
**Subject:** CORRELATION OF  
MEDICAID/  
MEDICARE  
REGULATIONS AND  
PROVIDER  
PAYMENTS

**Referred to:** Reference Committee  
No. 3  
(Albert M. Donato, M.D.,  
Chairman)

Whereas, At its July 22 meeting the Commission on Aging adopted the following; now, therefore, be it

Resolved, That this Commission on Aging go on record of accepting the concept of attempting to correlate Medicaid and Medicare in all matters of regulation and payment to providers; and be it further

Resolved, That this Commission, along with the assistance of all health providers represented at the July 22 meeting, and any other health providers deemed advisable, join in an effort to help accomplish this procedure, and be it further

Resolved, That this Commission refer this matter to the Board of Trustees and to the House of Delegates for their approval, and be it further

Resolved, That this matter be referred to the ISMA Commission on Legislation for necessary research and introduction in the next session of the Indiana General Assembly with possible referral to the Congress of the United States, and be it further

Resolved, That the Indiana State Medical Association make efforts to establish one simplified method of certification for the entire state of Indiana.



# Scientific Exhibits

CLAUDE J. MEYER, M.D.,  
Jeffersonville, Chairman

## CAROTID STENOSIS SURGICAL AND RADIOLOGICAL EVALUATION

**Exhibitor:** Austin L. Gardner, M.D.  
Indianapolis  
**Co-exhibitors:** Edward C. Wheeler,  
M.D., and Daniel R.  
Elliott, M.D., St.  
Vincent's Hospital,  
Indianapolis  
**Attendants:** Drs. Austin L. Gardner,  
Edward C. Wheeler and  
Daniel R. Elliott

A review of over 100 patients operated on for carotid stenosis will be presented using a videotape with a TV monitor. Patient interviews emphasizing modes of presentation of cerebrovascular insufficiency, physical findings, laboratory and radiographic studies, indications for operation, operative technique and results of surgical procedures will be continuously projected by TV monitor with a concurrent taped verbal description.

Charts, photographs, diagrams and x-rays shown on the videotape will be displayed in the booth.

The results of operations of patients operated prophylactically, those with transient ischemic attacks, progressive stroke, chronic ischemia and completed strokes will be considered.

## MEDICAL EDUCATION COMMUNICATIONS IN INDIANA

**Exhibitor:** Indiana University  
School of Medicine  
Indianapolis  
**Attendants:** Elmer Friman,  
Gloria Corki Wilson,  
Amy Fisher and  
Anabelle Paul

This exhibit graphically depicts the various utilization of communication systems for the distribution of continuing medical education programs by Indiana University School of Medicine. By pushing the proper button, lights on a map of Indiana will show the live, closed circuit, color Continuing Medical Education Network. Another button will light up the over 60 hospitals in the state

which are on the Video Tape Mailing Network (hospitals with equipment to play continuing medical education video tapes, most of which are supplied by the School of Medicine). Still other buttons will show where the School of Medicine utilizes local common carriers, CATV, cable, Instructional Television Fixed Service (microwave), and the Indiana Higher Education Telecommunications System to reach as many Indiana physicians with continuing medical education programs as possible. Literature will be available to detail the various network systems. Attendants will be on hand to answer specific questions.

Adjacent to the exhibit will be a color videocassette playback area for physicians to view continuing medical education tapes. Physicians viewing these tapes will be eligible to receive AAFP and AMA credit.

## EMERGENCY MEDICAL SERVICES TRANSPORTATION

**Exhibitor:** Emergency Medical Services Program Indiana  
State Board of Health  
Indianapolis  
**Attendants:** Robert K. Mills and  
Charles R. Hudson

A totally effective Emergency Medical Services System depends upon adequate emergency facilities, trained manpower, good communications, excellent emergency transportation vehicles, and a records (medical information) system, which will contribute to program evaluation and determination of areas of need.

Survival of victims of traumatic and medical emergencies may well depend upon the life-support capability of the emergency transportation vehicle. It must have space to contain adequate life support equipment and to allow effective, life supportive emergency care to be administered by trained emergency personnel.

Such a vehicle is on display in the exhibit hall for your information and perusal. You are encouraged to see this vehicle during the convention and ask any questions concerning the Emergency Medical Services Program in Indiana.

## VEIN BYPASS IN CORONARY DISEASE

**Exhibitor:** Harry Siderys, M.D.,  
Indianapolis  
**Co-Exhibitors:** John N. Pittman, M.D.  
Gilbert T. Herod, M.D.  
John L. Rubush, M.D.  
**Attendants:** Drs. Siderys, Pittman,  
Herod, Rubush and  
Pamela Linden, R.N.

Over the course of the last five years, we have performed more than 1,000 vein bypass grafts on more than 500 patients for the treatment of symptomatic coronary artery disease. Approximately one half of these patients have had good ventricular function and no complicating factors while one half have had some evidence of failure of the left ventricle or required concomitant operations such as repair of a ventricular aneurysm or replacement of an aortic or mitral valve. The results are particularly encouraging in those patients who have good ventricular function. However, in even those patients with fair ventricular function there is good evidence to suggest revascularization is of benefit. Improved surgical techniques and techniques of perfusion have resulted in a gradual lowering of operative mortality for this vein bypass operation. At the present time, it approaches mortality for other major surgery not involving cardiopulmonary bypass.

Follow-up studies have revealed relief of symptoms in the great majority of patients and evidence that the operation decreases the rate of myocardial infarction and prolongs life.

## GRADUATE PROGRAM—HEALTH ADMINISTRATION

**Exhibitors:** Dennis W. Dawes and  
Samuel H. Hopper, Ph.D.  
Hendricks County Hospital  
Danville  
**Attendants:** Dennis W. Dawes, Phil  
Fisher, Ken Stella, Greg  
Beethel and Jay Ott

Leading to the degree Master of Health Administration, the two-year academic program involves offerings by various schools of the University and



by cooperating community health agencies. The Department of Preventive Medicine of the School of Medicine, the academic staffs of the University hospital administrations, and the Indiana University Graduate School of Business provide a curriculum which covers such fields as management techniques, computer technology, and systems analysis applied to the dynamics of health care.

Specific courses include those dealing with organizational and human behavior, administrative policy, mathematical business analysis, epidemiology, accounting, electronic data processing, statistical tools, community facilities planning, public welfare and applied research, with special emphasis on problems in health care systems.

### INDIANA'S HEALTH MANPOWER DEVELOPMENT PROGRAM

**Exhibitor:** Indiana Health Careers, Inc.  
Indianapolis

**Attendants:** Jan Davidson, Executive Director; Consultants, Dee Hanna, Charles Blair, Thom Carroll and Bob Hammond, Operation MEDIHC

Indiana Health Careers is a not-for-profit service organization which counsels young people and adults into the health occupations field. The basic program is designed to promote a general awareness of the opportunities available. Consultants, trained to motivate and recruit for the more than 250 health occupations, conduct programs in all public schools in Indiana. Free information is made available to anyone upon request.

A special project of Indiana Health Careers' is Operation MEDIHC (Military Experience Directed Into Health Careers). This effort is designed to counsel separating military personnel into the health field by cooperating with hospitals and health facilities in utilizing the training and experience obtained by individuals while in the service. Indiana Health Careers was named the official MEDIHC Agency for the state in August 1970, and is rated among the highest in the nation in terms of successful job placement.

Another special project to counsel disadvantaged/minority students into the health and allied health field is also administered through the Health Careers Organization. Counselors offer services to the disadvantaged student through special assistance in guidance for education and training programs, financial aid,

and the enrollment process.

Recently, Indiana Health Careers has undertaken a comprehensive effort to survey health manpower and the health industry for the state. Data on selected professions is being compiled and kept current to more effectively project the requirements for qualified personnel in many areas. Thus, recruitment efforts will be matched more directly to the needs in Indiana.

All projects are interrelated and co-operate effectively to create an adequate base to develop health manpower for the state.

### A FOUR-POINT PROGRAM OF SERVICE TO THE HANDICAPPED OF INDIANA

**Exhibitor:** Indiana Easter Seal Society for Crippled Children and Adults, Inc.  
Indianapolis

**Attendants:** Thomas L. Thieken and Mary F. Elfers

Pictorially present the basic areas of service rendered through the Indiana Easter Seal Society to the handicapped of Indiana.

### THE WAY TO A MAN'S HEART

**Exhibitor:** Indiana Heart Association  
Indianapolis

**Attendants:** William R. Dudley, Jan I. Koontz, David Liven-good and Ray Cox

"The Way to a Man's Heart" is a colorful exhibit which calls to the attention of the public the Heart Association Program relative to diet and heart disease and the major changes in eating habits that are recommended.

The exhibit includes a rear screen projection and features a variety of three-minute animated films which give step-by-step recipes and helpful tips on fats, cholesterol and calories. Free recipe booklets on fat controlled, low cholesterol meals will be distributed.

### UNDERSTANDING THE PREGNANT ONE

**Exhibitor:** Suemma Coleman Home of Indianapolis

**Attendants:** Mr. Edward A. Freathy, Mrs. Elizabeth Hughes, Mrs. Barbara Butler and Miss Pamela Allen

Suemma Coleman Home of Indianapolis has been a resource of help to physicians and other referral agents in the care of the pregnant woman. As a

private social agency since 1894, this maternity home has continuously offered pleasant residential care, good counseling service and fine medical management for the girls. In more recent years we have served many pregnant women who lived outside the Home. Both married and unmarried expectant parents have sought our help. There is no restriction by reason of age, race, religion or residence. Family counseling is an integral part of our crisis-oriented services.

The agency program of help is geared to the individual's need and is carried out with understanding and compassion. Individual counseling, group therapy, social programs, education resources and well-planned medical and nursing care are combined to make this agency experience meaningful to the pregnant one. The new parent has the right and the responsibility to make plans for self and for the child. As a licensed child placement agency, the Suemma Coleman Home can place any child released by the parent(s) for adoption.

### NUTRITION IS FOREVER YOURS

**Exhibitor:** Dairy Councils of Indiana  
Indianapolis

**Attendants:** Mrs. Cathy Strain and Mrs. Hazel Burnett

Nutrition is Forever Yours: to inform, to promote, to implement.

Nutrition is a subject very much in the limelight these days. Much information, and much misinformation is dispersed. Because of this, Dairy Council feels it has a major responsibility working with paramedical personnel, professionals, and educators, as well as lay persons, in promoting accurate nutrition information.

This year's exhibit at the Indiana State Medical Association meeting will consist of nutrition education material available through the Dairy Councils which will assist the medical team in their programs concerning nutrition and nutrition education, whether it be in clinic, in consultation or in the classroom.

### CANCER OF THE SKIN—THE MOST COMMON AND PREVENTABLE CANCER

**Exhibitor:** American Cancer Society Indiana Division  
Indianapolis

**Attendants:** Marion County Unit Volunteers

The high incidence of skin cancer, now the leading cancer in this country in



terms of the number of patients affected, and the great potential for prevention are presented. Ninety per cent of cases of skin cancer are sun-related. The nature and risk of actinic skin damage are explained and protective measures are described.

The exhibit points out that while only about 5,000 deaths result annually from this disease, the mutilation and suffering which it causes could be greatly diminished through simple preventive measures, such as decreasing exposure to solar radiation by protective clothing and creams, and by early diagnosis and proper treatment.

**"HEMOPHILIA"**

**Exhibitor:** HEMOPHILIA OF INDIANA, INC.  
Indianapolis

**Attendants:** Mrs. Katie Milburn,  
James K. Pauley,  
Mrs. Joyce Sanders and  
Mrs. Mary Kent

Display with photographs, literature and other pertinent information pertaining to hemophilia. Current medical brochures will be available.

**IAFP—MEMBERSHIP AND EDUCATION**

**Exhibitor:** Indiana Academy of Family Physicians  
Indianapolis

**Attendants.** Mrs. Jackie Schilling,  
Mrs. Jackie Stahl and  
Mrs. Glenna Williams

The Indiana Academy of Family Physicians will have available information regarding the American Board of Family Physicians, educational requirements, membership applications and requirements, registration cards for the purpose of attaining credit for attendance at the ISMA meeting. Information will also be available for forthcoming educational programs in Indiana.

**PROSPECTIVE PROBLEM ORIENTED RECORD**

**Exhibitor:** Ronald Blankenbaker, M.D.  
Indianapolis

**Co-Exhibitors:** Family Practice Residents, Methodist Hospital  
Indianapolis

**Attendants:** Ronald Blankenbaker, M.D., and/or a resident from the Family Practice Program

There is a time when the probability of developing a particular disease is

minimal, i.e., the risk is zero. Next comes a period when the person is at risk of becoming diseased followed by a time when the agent of disease is actually present. Subsequently, the patient develops signs which can be observed by the physician, symptoms which the patient himself observes, then disability and finally death. The only way to prevent the development of this disease is to catch the patient when he becomes "at risk"—long before he tips us off by signs of disease.

Prospective medicine, a term coined by Robbins and Hall<sup>1</sup> is a new form of health care based upon this principle; it is (a) comprehensive in its concern for the individual's total risk (b) continuous in its search for new risks, and (c) initiated before disease and injury, beginning with a quantitative estimate of the patient's own risks and a program of priorities for their reduction.<sup>2</sup> It organizes preventive medicine and health maintenance into an easily usable fashion for the busy practitioner.

This exhibit will present this new concept of medical care and show how it can very readily be integrated into a simplified version of Weed's Problem Oriented Medical Record.<sup>3</sup> It will also show how this prospective approach to the patient and his record can be adequately used in the busy physician's office.

1. Robbins, Lewis C. and Jack H. Hall, *How to Practice Prospective Medicine*, Indianapolis, Methodist Hospital of Indiana, 1970.
2. Hall, Jack H., Lewis C. Robbins, and Norman B. Gesner, *Whose Health Problem? Postgraduate Medicine*, 51, 114-120, January 1972.
3. Weed, Lawrence L., *Medical Records, Medical Education and Patient Care*, Year Book Medical Publishers, Chicago, 1971.

**WOMANLY ART OF BREAST-FEEDING**

**Exhibitor:** LaLeche League of Indiana

**Attendants:** Representatives of the LaLeche League of Indiana

Information will be available regarding organization's name, motto and symbol, purpose and type of services available. Literature (reprints, pamphlets and booklets) will be available.

**TOXICOLOGY LABORATORY IN MEDICAL CARE**

**Exhibitor:** Dr. Daniel J. Brown  
Department of Toxicology  
Indiana University  
School of Medicine

**Co-exhibitors:** Dr. David Doedens  
Robert C. Martz, M.D.  
Dr. Robert B. Forney

**Attendants:** Various members of Department of Toxicology

The contribution of the toxicology laboratory in the management of chemical and drug induced illness will be examined. The proper selection of samples and the interpretation of data from analysis of these samples for many commonly occurring poisons will be illustrated.

**DIAGNOSIS—TREATMENT: ACOUSTIC TUMORS**

**Exhibitors:** John M. Tew, Jr., M.D., and Sabino Baluyot, M.D., Cincinnati

**Co-exhibitors:** Robert Lukin, M.D., and Richard J. Wiet, M.D., Cincinnati

**Attendants:** Drs. John W. Tew and/or Sabino Baluyot

Modern otology and radiology provide the methods for accurate diagnosis of acoustic nerve tumors. Advances in surgical techniques permit total tumor removal with preservation of normal neurologic function if the tumors are recognized during the early stage of growth (stage I). Yet, discovery of the lesion when small and easily removable depends on the suspicion and acumen of the primary clinician.

The acoustic neuroma originates as a result of a neoplasia of Schwann cells on the eighth cranial nerve within the internal auditory canal (IAM). It is a benign tumor whose presence may be recognized by symptoms related to eighth nerve compression and expansion of the tumor into the cerebello-pontine angle.

Small tumors (stage I) or intracanalicular neuromas are confined to the internal auditory canal. Signs and symptoms include deafness, tinnitus, and dizziness. Hearing loss is classically unilateral and progressive. Diagnosis may be facilitated by examination of the eighth nerve by the tuning fork (auditory) and caloric tests (vestibular).

Medium size or stage II tumors, up to 2.5 cm., may compress neighboring



cranial nerves. Facial weakness (VII nerve) may be a complaint. Numbness and paresthesias indicate trigeminal (V nerve) involvement; a diminished corneal reflex is the earliest sign of fifth nerve compression.

Late or stage III tumors, larger than 2.5 cm., may compress the lower cranial nerves (IX, X, XI) resulting in dysphagia and dysphonia. Symptoms of headache, blurred vision and ataxia usually indicate increased intracranial pressure. Involvement of the brain stem and cerebellum result in ataxia and hydrocephalus. Death may be impending.

When an acoustic tumor is suspected the patient should undergo neurotologic and radiographic examinations designed to establish the definite cause of the symptoms. Treatment is surgical and a pleasing recovery can be expected in patients with early stage tumors. Although total removal can be achieved in stage III tumors, it is frequently at the expense of significant loss of neurologic function such as facial palsy, facial numbness and increased ataxia.

**TRIGEMINAL NEURALGIA: A NEW SURGICAL APPROACH**

**Exhibitors:** John M. Tew, Jr., M.D., and Frank H. Mayfield, M.D., Cincinnati  
**Attendants:** John M. Tew, M.D.

Trigeminal neuralgia was described as early as the First Century A.D.; therefore, it is unlikely that any surgical approach to this disorder can be entirely new. Yet, recent modifications in stereotaxic surgery suggest that percutaneous electrocoagulation may surpass previous forms of surgical therapy in the treatment of trigeminal neuralgia.

Kirshner, a German, introduced the technique of cauterization of the trigeminal ganglion in 1931. After several hundred cases, in which the trigeminal ganglion and rootlets were coagulated with the Bovie electrosurgical units, the

procedure was abandoned principally because of complications resulting from uncontrollable spread of heat to adjacent cranial nerves and arteries. In the meantime, other surgical procedures gained favor and the first truly effective forms of medical therapy became available. Consequently the complicated modes of surgical therapy were performed with decreasing frequency.

Four factors played a role in the development of this advanced form of surgical treatment:

1. Experience proved that stereotaxic surgical technique permitted precise localization of minute nerve fibers by stimulation and reversible thermal lesions.
2. The development of a highly effective radio-frequency lesion generator capable of producing standardized current in megacycle frequency range. Precise control of such a current by temperature monitoring produces a uniform thermal lesion.
3. Anesthetic techniques capable of producing short lived analgesia without prolonged sedation. Sensory testing in an awake subject is required for the successful production of graded destruction of trigeminal pain nerve fibers.
4. Most importantly, it is possible to achieve lasting relief of pain with only partial destruction of the trigeminal nerve. Since the smaller poorly myelinated fibers which carry pain are more sensitive to thermal (heat) lesions, they can be selectively destroyed while the large fibers which mediate touch and motor (mastication and facial motions) function are preserved.

In 1965, this technique was initiated by Dr. William Sweet of Boston who served as my teacher. Subsequently, in 1969, it became our practice to apply this procedure in selected cases. It has now become the surgical procedure of choice when medical therapy is unsatisfactory. Our experience now exceeds 100

procedures. Excellent results have occurred in 90% of the cases, recurrence of pain in 10% of the patients has required repetition of the procedure in the four year period. A satisfactory relief of pain has occurred in 98% of the cases. Undesirable complications include: temporary extraocular palsy 2%, corneal anesthesia 6%, corneal ulceration 4%, and temporary masseter weakness 15%. There have been no permanent side effects other than those involving the trigeminal nerve.

**COMMITTEE TO COMBAT HUNTINGTON'S DISEASE — INDIANA CHAPTER**

**Exhibitor:** Indiana Chapter of the Committee to Combat Huntington's Disease, Inc.  
**Attendants:** Mrs. Wanda C. Wyne, Madison

Our exhibitor consists of three poster boards and one x-ray with typewritten sheets explaining Huntington's (Chorea) Disease in general and also a large portion devoted to research of the disease. Pamphlets telling about the disease will be distributed and examples of our Physician's Kits and Family Information Packets will be on display.

**SMOKING AND HEALTH**

**Exhibitor:** Indiana Interagency Council on Smoking and Health, Indianapolis  
**Attendant:** Jerry Maburn, Indianapolis

**HUNTINGTON'S (CHOREA) DISEASE**

**Exhibitor:** Ott B. McAtee, M.D. Madison State Hospital Madison, Indiana  
**Attendant:** Terrill Grant



# Technical Exhibitors—1973

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# The JOURNAL

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**"Indiana Frontiers in Medical Education"**





Everybody experiences psychic tension.



Most people can handle this tension.



Some people develop excessive psychic tension and need your counseling,



and a few may need counseling  
*and* the psychotropic action of Valium® (diazepam).



Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect.

*Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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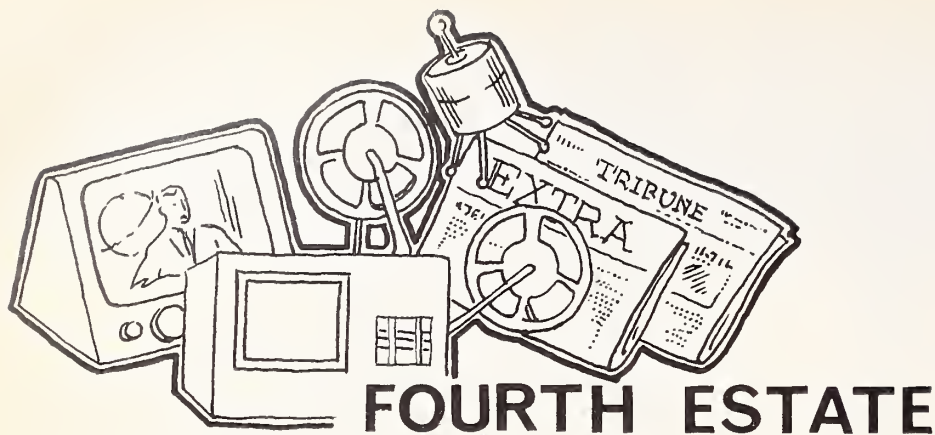


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## Wearing Both His Hats

Gov. Otis Bowen understandably devotes much more time to his governmental than to his medical career these days, but he is now combining the two on one program in which we wish him success.

That's because success could mean saved lives.

The Emergency Medical Services (EMS) program on which the governor has been working quietly got a public launching this week in a conference at the statehouse.

It got a launching of support, that is. Its official implementation will require legislative approval and, doubtless, some money. But lives saved should be worth it.

The goal is to require that by Jan. 1, 1976, all emergency ambulances in Indiana have two-way radios and that by Dec. 31 of that same year all emergency ambulance personnel be at least emergency medical technicians.

The concept isn't new, but neither is it cheap.

A couple of years ago a series of articles in *The Post-Tribune* pointed out the lack of medical knowledge—even of basic first aid training—on the part of those who operated ambulances here.

The first result was for the funeral home directors to point out they were running ambulances as a public service and generally at a loss and could not afford the kind of

trained help desired. As an upshot they went out of the ambulance business.

The city brought in an authorized ambulance service, but even the help it provided lacked the training needed. Further, the service went on losing money.

That's why here the City Council has now authorized the Fire Department to take over the ambulance service beginning sometime this fall. Steps are being taken to provide advance training. Pay scales are being altered for some as an added spur to more efficient service. How well the system will work only time will tell, though some cities have found it highly satisfactory.

We appreciate former Councilman William McCallister's civic and economic concern in warning against the path Gary is taking, but we still think overall the experiment is merited. We trust, though, city officials are cognizant enough of the warning to try to keep costs of the new service within bounds, and we doubt the wisdom of cutting fees as drastically at the outset as Mayor Richard G. Hatcher has suggested. Primarily, ambulance fees should be paid by the individual or family served, through insurance where possible.

However, not that much progress has been scored everywhere in the state. Further as of now there is no higher level check on how effective city service may be. Presumably the

This section of *THE JOURNAL* is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

proposed EMS legislation is designed to take care of that.

As we said earlier, this isn't going to be achieved without spending money. Some foundation aid is anticipated at the outset. But for the long haul, some kind of public subsidization will be needed.

If Bowen is right in his figures that 60,000 accident victims die needlessly each year nationally, the money spent in saving a large number of Indiana's share of those deaths would be a sound investment.—*Gary Post Tribune*, July 27, 1973.

## Protest Hospital Rate Hike!

One of the most common gripes these days is over increasing hospital costs.

Last week's *Journal* revealed room rates at Pulaski Memorial Hospital probably would increase \$4 per day as a result of more federal gobbledygook.

It is about time the public stood up and said, "Enough!"

Rulings and guidelines issued by the state hospital licensing agency and HEW have resulted in the increase in the amount to be set aside for "uncompensated services" or charity. The hospital had set aside \$11,000 for charity this year. However, the state agency ruled it wasn't enough, and hiked the figure to \$21,246.

The hospital, therefore, must



raise the additional \$10,000 by the end of the year. The regulations do not pertain to Medicare patients—54 per cent of the total patient population here.

This means 46% of the hospital patients must bear this burden. Room rates would be \$49 per day for a semiprivate room.

The hospital's "sin" is it took \$455,000 in federal Hill-Burton money in 1962. It now must abide by HEW guidelines.

There are several reasons the Journal believes the amount for charity is excessive.

1. The amount is far above the highest yearly figure for charity at the hospital—\$16,000.

2. The needed charity is being supplied. No one is being turned away.

3. It is unfair that 46% of the patients should bear the burden.

Many citizens believe the only thing to do when trapped by Federal regulations is to surrender.

Hospital administrator Ted Kittell believes there might be one recourse. And The Journal agrees.

That recourse is to write the state, protesting the increase.

Kittell believes that if the state would get 300 or 400 letters it would help an appeal by the hospital board.

The Journal believes it's time to turn that gripe about increasing hospital rates to action. It's a test to see if we are really fed up.

In order to protest write: *William T. Paynter*, State Health Commis-

sioner, Indiana State Board of Health, 1330 West Michigan Street, Indianapolis 46206.—*Winamac-Pulaski County Journal*, August 8 1973.

## For Safer Ambulances

**T**HERE'S a workshop scheduled at Indiana University Northwest campus next week in which the whole area has a stake.

It's a "Seminar-Workshop on Emergency Care and Transportation of the Sick and Injured" sponsored by the Northwest Indiana Emergency Care Training Course Committee, which includes representatives of the Lake County Medical Society, the five Lake County hospitals, area clinic groups, the Northwest Indiana Heart Association, the Hammond Fire Department and the Continuing Nursing Education Program at IUN. It runs from Monday through Thursday noon.

What it's about is helping to train those who either as professionals or volunteers, whether in connection with professional or volunteer fire departments or otherwise, may be involved in handling emergency ambulance service.

It's an opportunity for members of the Gary Fire Department, who will soon be taking over ambulance service here, and for volunteer fire departments and others in the area.

It keys in with the program being

pushed statewide by Gov. Otis Bowen for an emergency medical services program throughout the state. Hopes from the state level are to have legislation passed in next year's session requiring specified training for all those engaged in ambulance service.

Dr. T. F. Fisher, plant medical director for U.S. Steel's Gary Works, and one of the doctors on the faculty for the three-and-one-half day session, says it is anticipated that the work will count as 20 hours toward the 81-hour training program eventually expected to be mandatory.

But the need, of course, is more immediate than that. Those engaged in such service now should make it a point to get all the training they can as soon as possible. Groups most directly concerned should make it a point to get people registered quickly. The registration deadline is tomorrow.

Joining Dr. Fisher on the faculty are Doctors William F. Nowlin, Jack M. Kamen, John T. Scully, Albin A. Jahns, Robert S. Martino, Robert L. Young, Farida I. Chua, Edward Zucker, Tieh Wang and John T. King, along with Atty. Clarence Borns, Donna Brown, a registered nurse and IUN nursing professor, Bn. Chief Milton Stanford of the Hammond Fire Department and Joseph J. Gregor, director of Lake County Civil Defense.

Take advantage of it.—*Gary Post-Tribune*, August 16, 1973.

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Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 3266 N. Meridian St., Room 705, Indianapolis 46208. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.

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**Indications:** Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

**Contraindications:** Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anti-coagulant therapy.

**Warnings:** Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against po-

tential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonyleurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

**Precautions:** The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

**Adverse Reactions:** This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia,

gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement. (B)98-146-800-F (10/71)

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**Contraindications:** Known hypersensitivity to flurazepam HCl.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

**Precautions:** In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

**Adverse Reactions:** Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

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# Opinion & Dialogue

## "Prescription drugs – who should determine the maker?"

### Dispenser of Medicine

Clifton J. Latiolais  
President  
American  
Pharmaceutical  
Association



### Maker of Medicine

C. Joseph Stetler  
President  
Pharmaceutical  
Manufacturers  
Association



"Too many doctors are indifferent to the economic consequences of their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by former AMA Chief Executive F. J. L. Blasingame, M.D.

#### Doctor, are you indifferent...?

In discussing an anticipated increase in Blue Shield rates, Dr. Blasingame's newsletter had this to say:

"In general, it can be said, MD's have given the impression they are not particularly concerned with the increase in cost of health care to the patients..."

"True, an MD's training is primarily scientific, but in the real world of practice, all of his scientific decisions have a price tag, or an economic impact. The economics of health care beckon the practitioner's attention. Concern for economics of medicine

When the pharmacist recommends that a drug product other than the one ordered be dispensed, the prescriber invariably permits the change when he feels the best interests of the patient will be served.

#### Shortcomings of Pro-Substitution Argument

The fact remains that it is necessary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, the unilateral decision of the pharmacist made in the absence of clinical knowledge of the patient, could expose him to needless risks, and in addition, jeopardize the relationship between the professions of Pharmacy and Medicine. In my view, there is nothing in the pro-substitution argument that offsets these risks.

#### The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowledge about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degree puts him at a disadvantage. Most often, a practicing physician will need expert knowledge of no more than 25



should be an obligation of medical practice...

"Medical societies ought to conduct continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in the patients' interest, question the tactics of any insurance organization that raises health care costs by forcing policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed to their patients for support in the fight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

### Cost of Drugs

Insurance rates and hospital charges are only two factors in health

or 30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with the particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substituting pharmacist may avoid even a technical breach of contract by simply notifying the patient that he is making the substitution. I would judge that few courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

### Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could allow legalization of substitution. We have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests

care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists *are concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

### Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining

high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

### APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

*(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)*

the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

### Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

### Summary

In short, what the American Pharmaceutical Association advo-

cates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

*(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)*

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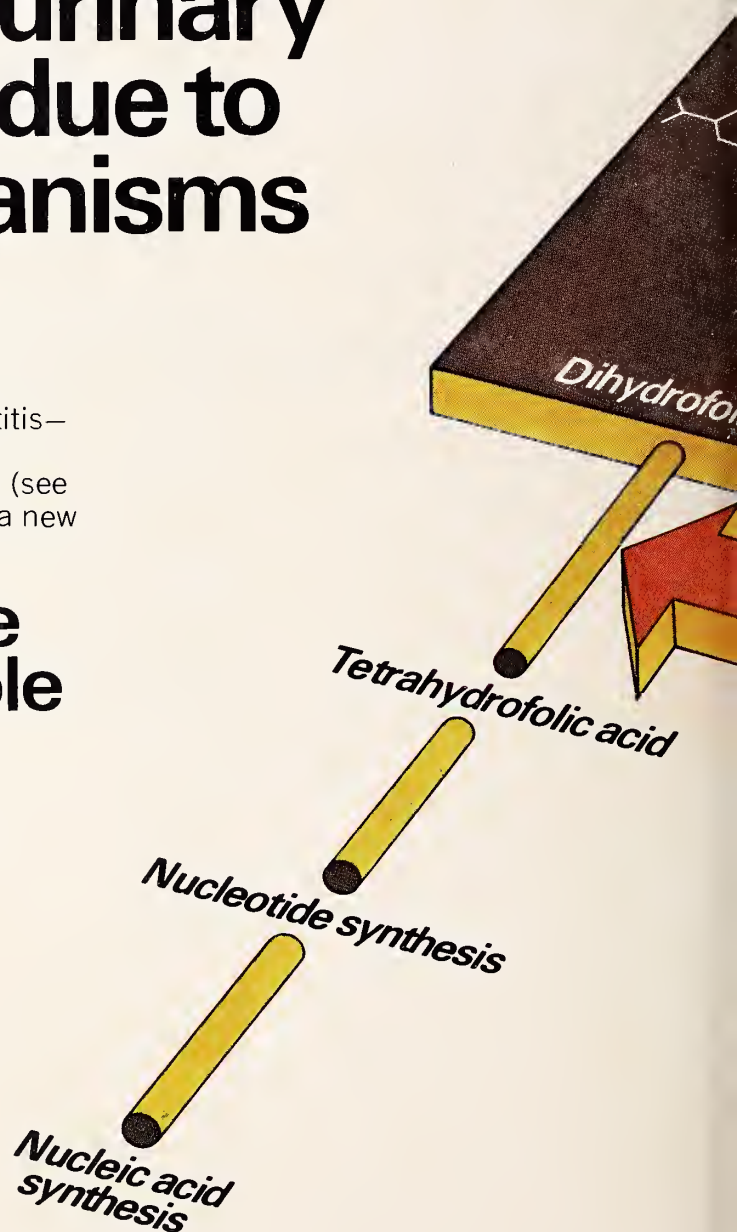
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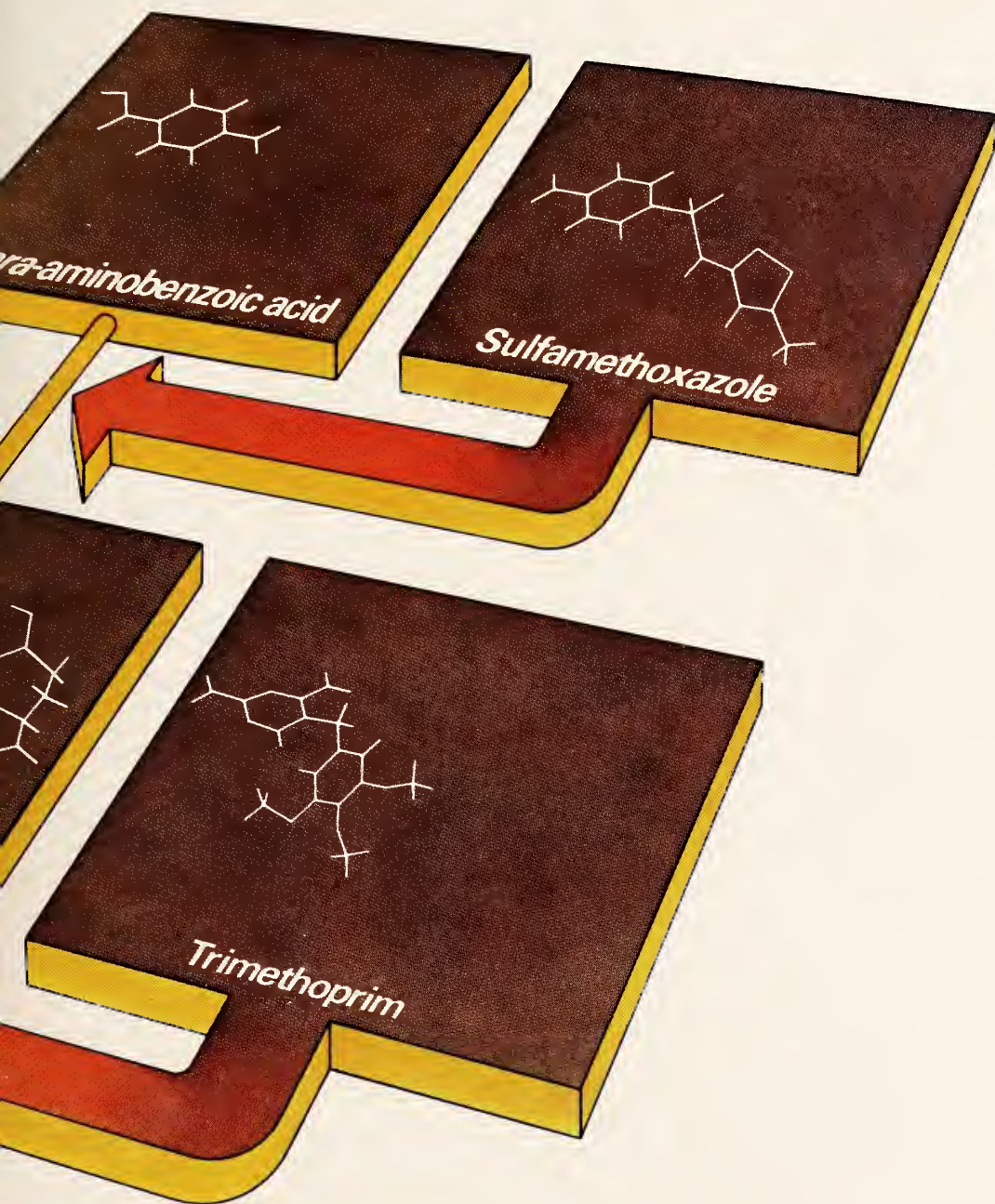
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A multiclinic, double-blind study\* of response to a ten-day course of therapy in 471<sup>†</sup> patients with chronic urinary tract infections demonstrated the superiority of Bactrim. On the 10th day after initiation of therapy, 91.7% (of 168 patients) showed significant bacteriological response to Bactrim, compared with 81.2% (of 144 patients) to trimethoprim and 64.5% (of 155 patients) to sulfamethoxazole. More than half of these patients had obstructive complications.

## Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after a ten-day course of therapy with Bactrim, 68.4% of patients with chronic urinary tract infections *maintained* response for up to 42 consecutive days, compared with 59.7% with trimethoprim and 44.4% with sulfamethoxazole. These results are particularly noteworthy considering the number of patients with obstructive complications—cases regarded as being notoriously difficult to treat.

## Prescribing considerations

**Clinical Limitations:** Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections. Not recommended for children under twelve.

**Contraindications:** Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period.

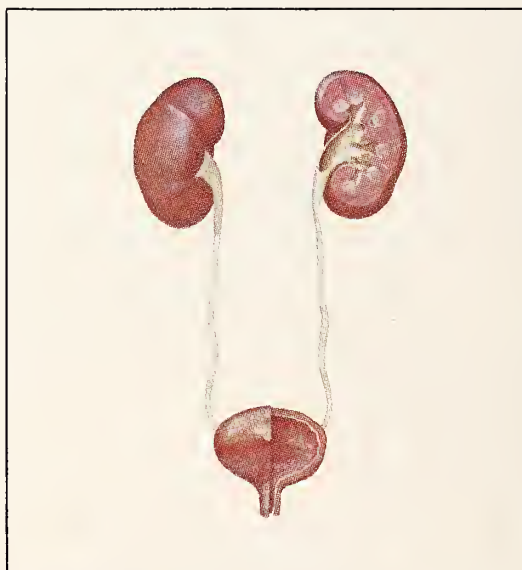
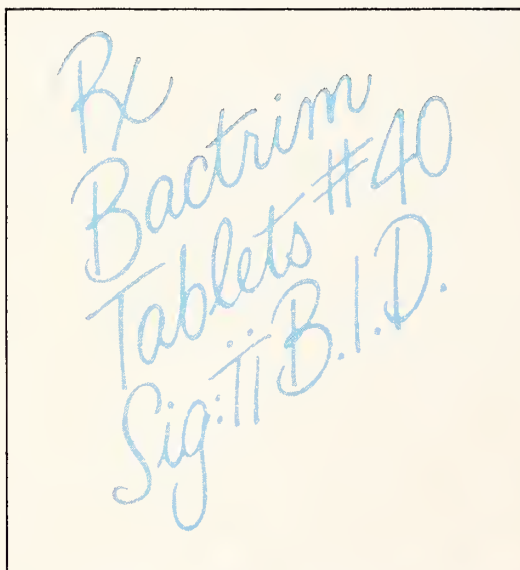
**Warnings and Precautions:** Both sulfamethoxazole and trimethoprim have been reported to interfere with hematopoiesis. Complete blood counts should be done frequently. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued. Bactrim should be given with caution to patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. Maintain adequate fluid intake. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

**Adverse Effects:** Among the most common side effects are nausea, vomiting, rash, leukopenia and elevations in SGOT and creatinine.

**Usual adult dosage: two tablets every twelve hours for 10 to 14 days; no loading dose required.**

\*Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110

<sup>†</sup>4 patients not available for evaluation at day 10.



new **BACTRIM**™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

**for chronic urinary tract infections**



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110



Complete Product Information:

**Description:** Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is N<sup>1</sup>-(5-methyl-3-isoxazolyl)sulfanilamide. It is an almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

**Actions: Microbiology:** Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with para-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

*In vitro* studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

*In vitro* serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa*. The following organisms are usually susceptible: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis* and indole-positive proteus species.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms (MIC—mcg/ml)				
Bacteria	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20)	
			TMP	SMX
<i>Escherichia coli</i>	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
<i>Proteus</i> spp. indole positive	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
<i>Proteus mirabilis</i>	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
<i>Klebsiella-Enterobacter</i>	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

**Human Pharmacology:** Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. On repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma decreases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than are the concentrations in the blood. When administered together as in Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

**Indications:** Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, and, less frequently, indole-positive proteus species).

**Important note:** Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.

**Contraindications:** Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction Studies).

**Warnings:** Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

**Precautions:** Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

**Adverse Reactions:** For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

**Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

**Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

**Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

**C.N.S. reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

**Miscellaneous reactions:** Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

**Dosage and Administration:** Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/ min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

**How Supplied:** Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

**Reproduction Studies:** In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

**BACTRIM** T.M.  
Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110



# THE INDIANA STATE MEDICAL ASSOCIATION

3935 N. Meridian, Indianapolis 46208—Telephone 925-7545  
ANNUAL CONVENTION—OCTOBER 6-11, 1973—Indianapolis

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Executive Secretary—Mr. James A. Waggener, 3935 N. Meridian, Indianapolis 46208.

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2—Paul W. Holtzman, Bloomington	Oct. 1975
3—Eli Goodman, Charlestown	Oct. 1973
4—Howard C. Jackson, Madison	Oct. 1974
5—Cleon M. Schauwecker, Greencastle	Oct. 1975
6—Paul M. Inlow, Shelbyville	Oct. 1973
7—John O. Butler, Indianapolis	Oct. 1974
8—Joseph F. Ferrara, Franklin	Oct. 1975
9—Richard Ingram, Montpelier	Oct. 1975
10—William M. Sholty, Lafayette	Oct. 1973
11—Vincent J. Santare, Munster	Oct. 1974
12—James A. Harshman, Kokomo	Oct. 1975
13—William R. Clark, Fort Wayne	Oct. 1973
14—G. Beach Gattman, Elkhart	Oct. 1974

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District	Term Expires
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2—Betty Dukes, Dugger	1974
3—Thomas Neathamer, Jeffersonville	1974
4—William Blaisdell, Seymour	1973
5—William G. Bannon, Terre Haute	1973
6—Glen Ward Lee, Richmond	1975
7—John Pantzer, Indianapolis	1975
8—Donald McCallum, Indianapolis	1974
9—Jack L. Alexander, Muncie	1973
10—Max N. Hoffman, Covington	1974
11—Martin O'Neill, Valparaiso	1975
12—Lloyd L. Hill, Peru	1974
13—Walter D. Griest, Fort Wayne	1974
14—Donald S. Chamberlain, South Bend	1973

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Lowell H. Steen Hammond	Thomas C. Tyrrell Hammond

Terms expire December 31, 1974:

Delegates	Alternates
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Eugene F. Senseny Fort Wayne	Ross L. Egger Daleville
Malcolm O. Scamahorn Pittsboro	Kenneth O. Neumann Lafayette

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6.	James H. Tower, Jr., Shelbyville	Arlington M. Hudson, Connersville	
7.	Eric Clark, Plainfield	M. O. Scamahorn, Pittsboro	
8.	David Dietz, Muncie	Arthur Jay, Muncie	
9.	Milton W. Erdel, Frankfort	Harry T. Stout, Frankfort	June 13, 1974, Frankfort
10.	Mario D. Mansueto, Munster	James R. Brown, Valparaiso	
11.	Joseph S. Bean, Logansport	Fred Poehler, La Fontaine	
12.	George C. Manning, Fort Wayne	William B. Hughes, Waterloo	
13.	Jack Hannah, Elkhart	David L. Spalding, Mishawaka	Sept. 11, 1974, Elkhart





## Placidyl® (ETHCHLORVYNOL)

### Brief Summary

**Indications**—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

**Contraindications**—Drug hypersensitivity and porphyria.

**Warnings**—Not recommended during the first and second trimester of pregnancy. Caution patients for possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, blurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

**Precautions**—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuance of the drug. Drug dosage should be limited in the elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitriptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients do not respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, syncope without marked hypotension. Transient dizziness or ataxia may occur.

**Adverse Reactions**—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction (manifested by urticaria) have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 306433

## Give us his nights.

Prescribe Placidyl. Chances are, we'll give him a good night's sleep.

Insomnia often accompanies a cardiovascular episode. How many nights does he lie awake, awaiting exactly what he fears most . . . another stroke, another heart attack? He doesn't need fear. He needs sleep.

When sleep is synonymous with therapy, remember . . . Placidyl is synonymous with sleep. It has been for over 17 years.

If time is the criterion to inspire your confidence . . . you can rest assured with Placidyl.

Prescribed by physicians for over 17 years.

## Placidyl®

Ⓓ

(ETHCHLORVYNOL CAPSULES, 500 or 750 mg.)





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### Federal Aid for 100 New HMOs Anticipated

Legislation providing federal aid for establishment of a limited number of experimental Health Maintenance Organizations (HMO's) bills advanced in Congress. The House bill was much smaller in scale (five years, \$240 million, compared to \$805 million) than one passed by the Senate.

In a report on the HMO bill, the House Commerce Committee discussed HMOs and their possible future role in health delivery. No specific number limitation was set in the House bill, but "it is anticipated that the limit of authorizations to \$240 million and the reality of the budget and appropriation process will provide an effective ceiling on the number of HMOs which could be established . . . Generally, however, the committee would anticipate that this legislation would be used to bring to the operating stage approximately 100 new HMOs."

The report stressed a five-year cut off. "All federal assistance to all assisted HMOs will be completed by the end of five years for which authority is given. Thus, there will be no need to extend or renew this legislation in order to meet outstanding commitments."

After a discussion of "many arguments in favor of HMOs," the report said the committee "is concerned about the fact that HMOs (pre-paid group practice, contract practice, etc.) have not grown more rapidly than has been the case." The committee said it hoped the HMO program would clarify many problem areas, including such basic questions as "will federal assistance to HMOs work?" Other matters of concern were listed as whether federally aided HMOs will be able to survive without federal help; how well will such organizations serve the poor, chronically ill, and aged; how will they work in ghettos, rural areas; what about consumer acceptability, quality of services, etc.

Noting that an HMO operates under an income limit (the premiums paid), the committee said one fear is that "it would be possible for an HMO to respond to

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to The Journal on the first of each month preceding month of issue.

this limit by discouraging the utilization of its services. For example, the committee is concerned with the possibility that elective surgery such as cataract extractions in elderly people, might be delayed in situations where an HMO is experiencing higher than expected utilization. These practices are to be discouraged."

Cautioning against allowing an HMO to have a monopoly anywhere, the Committee said:

"The heterogeneity of the HMOs envisioned by the committee is the key characteristic of the HMO program authorized by this legislation and deserves particular comment.

"In preparing the legislation, the committee has attempted not to describe exhaustively or in detail a single 'proper' system for the delivery of health services. The legislation defines desirable qualities for any system for health care delivery and offers to support any HMO which includes these qualities, however it may be structured or organized in detail. **Thus, the HMO program sponsored by this legislation would not represent a single monolithic or federally controlled health system, but a series of additions to our existing pluralistic system.**"

The Committee said that one reason there are few HMO-type programs operating now "is the high cost of planning, development, and initial operations. It has been estimated that the group practice model requires as many as 30,000 enrollees before the plan breaks even with as much premium income as expenses. Planning costs for this type of HMO can go up to a half million dollars. Operating deficits until the break-even point can amount to \$2-3 million."

Unlike the Senate bill, the House legislation does not preempt state laws that restrict formation of HMOs. The reason given by the House Commerce Committee was "the rapid change already underway in state legislation designed to remove these barriers . . . approximately 20 states have already adopted legislation specifically authorizing HMOs."

Continued



# ISMA Committees and Commissions for 1972-1973

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### Retirement Savings Restriction

The outlook in Congress for a new restriction on retirement savings of professional service corporations and a companion liberalization of the Keogh plan for the self-employed was cloudy. Opposition to the limitation on the professional service corporations was reported strong in the House, though the Senate was expected to approve it.

The Senate Finance Committee said in its report on the bill that "it is contended that the present law in the retirement plan area creates an artificial incentive for the incorporation of businesses which more traditionally, and perhaps more appropriately, have been conducted in unincorporated form."

The committee restricted the amount an incorporated professional could save for retirement purposes and receive federal income tax deferral to \$7,500 a year and not more than 15% of income. The Keogh plan was liberalized to the same levels.

Noting that in recent years all states have adopted special incorporation laws which allow professional corporations, the committee said these "have been used increasingly by groups of professional persons, primarily to obtain the more favorable tax treatment for pensions generally available to corporate employees." The Internal Revenue Service's adamant opposition to these corporations and refusal to recognize them in the so-called Kintner regulations was rejected by the courts until "the service has now acquiesced and generally recognized these professional corporations as corporations for income tax purposes."

The committee said "the formation of professional corporations, a practice which has proliferated enormously in recent years, has had the effect of circumventing the limitations which Congress intended to impose on deductible contributions by persons who are essentially, in most respects, self-employed."

Explaining why it didn't impose any limit on regular corporation tax deferrals for high-salaried executives, the committee said that in corporate plans a "much larger percentage of the contributions and benefits go to the 'rank and file' employees." This "financial drag effect tends to impose practical restrictions. . . ."

### Librium, Valium Action

Librium and Valium will be subject to tighter federal restrictions. Under a Justice Department proposal, which has been accepted by the manufacturer, Roche Laboratories, the two tranquilizers will be placed in category IV of the Controlled Substances Act. Other

major tranquilizers already are in this category.

A prescription may be refilled no more than five times and a written prescription would be valid for no longer than six months. A renewal of the prescription after these limits would require a written prescription.

The proposal would place additional record-keeping and other requirements on drug manufacturers and pharmacists. Primary aim is to prevent diversion into illicit channels.

### Cough-Cold Drug Action Delayed

The Food and Drug Administration agreed to delay action against prescription cough, cold and allergy products. Interim guidelines will not be implemented until the FDA's over-the-counter review panel has issued a monograph, not expected until next year. Controversial guidelines issued last spring would have prohibited the use of combination antitussives and/or expectorants or decongestants for the common cold and the use of antitussives combined with antihistamines and decongestants for allergic or vasomotor rhinitis. Pharmaceutical and medical groups protested then the lack of input from the medical profession on the proposed ban. Witnesses urged that action be postponed until the scientific community can review the OTC panel's report which is slated to cover much the same ground.

### Ruling on President's Veto of Family Practice Aid Bill to Be Appealed

The Administration is planning to appeal a District Court Judge's ruling that President Nixon's pocket veto in 1970 of legislation to aid training in the practice of family medicine was unconstitutional.

The veto of the \$225 million bill to help hospitals and medical schools set up family medicine departments came during a Christmas recess of Congress. The President claimed he killed the bill by use of the "pocket veto" by refusing to sign the bill while Congress was out of town. Sen. Edward Kennedy (D., Mass.) who filed suit against the President, contended that it was an improper use of the "pocket veto." Actually, he said, the bill became law because the President did not veto it in the normal way, thus giving Congress the chance to override it.

The Constitution gives the President 10 days in which to sign or veto a bill passed by Congress. If he does neither and Congress is in session, the bill automatically becomes law. If Congress is in adjournment, the bill dies.

U. S. District Court Judge Joseph Waddy in Wash-

Continued





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Powdered opium, USP. . . . .	24.0 mg.
(equivalent to paregoric 6 mL.)	
(warning, may be habit forming)	

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ington, D.C., held that the recess in question did not constitute an adjournment. The Judge gave the Administration until Sept. 9 to comply with his order.

### Administration's Health Goals

HEW Secretary Caspar Weinberger said that health care improvements will come from building "on our historic existing strengths" rather than "tearing down the entire structure because of our dissatisfactions."

In an address to the American Health Congress in Chicago, the Secretary said his Department was "absolutely and totally committed to do whatever may be necessary to assure that quality health care is readily and equally available to every American."

He said, however, that meeting this goal means devising "a total health strategy in which every possible program or option is carefully and objectively weighed—against each other and against the limits of our present revenue resources—before decisions are made."

"No longer are we committed to support all ongoing programs," said the Secretary, "just because we once decided to start them."

"We have made the basic decision to build on our historic strengths in the health care field," he said, "closing obvious gaps, making needed improvements and instituting prudent innovations—rather than tearing down the entire structure because of our dissatisfactions and starting on something entirely different."

He said the nation would not stand by while inner city residents lack decent health care, 120 American counties are without medical facilities and health personnel, costs skyrocket past the means of average citizens, and "the dangerous trend toward overspecialization in medical practice" continues.

"This Administration is prepared to pay the bill for an improved health care system," said Secretary Weinberger, "but only for concrete results."

He said that means "that while we're raising the Federal investment in health care—we are also reducing the unrealistic expectations of some program managers. We are also determined to make each Federal dollar stretch further."

He noted that for the current fiscal year, "the President has proposed a 21% increase in health funding. That amounts to nearly \$4 billion more—and brings the total Federal health investment to nearly twice the annual amount spent when President Nixon took office."

He said the Administration's "total health strategy involves a number of new initiatives and a conscious attempt to weave together existing programs which meet well-defined needs and new approaches which not only fill present gaps, but will meet estimated future needs."

He said the four highest priorities are:

National health insurance, Health care cost control, the national cancer and heart programs, and movement toward an all-volunteer blood supply.

### V. A. Bill Into Law

Legislation signed into law by President Nixon extends Veterans Administration medical care to certain dependents, assures peacetime veterans the right to V.A. medical care and streamlines V.A. rules on health care delivery.

Outpatient medical care for non-service-connected conditions is authorized when it would avoid the need for hospitalization.

The law, effective September 1:

- Extends eligibility for medical care to the wife or child of a person who has a total and permanent disability, resulting from a service-connected condition, and to the widow or child of a person who has died of a service-connected condition. Care will be provided in a manner similar to that in which medical care is furnished by the Armed Forces under the CHAMPUS program to dependents and survivors of active duty and retired personnel.

- Removes the requirement for wartime service as a condition of eligibility for V.A. medical care.

- Liberalizes rules on providing VA outpatient or ambulatory care. Any veteran who is now eligible for VA hospitalization can be treated as an outpatient, if necessary to preclude the need for hospital admission.

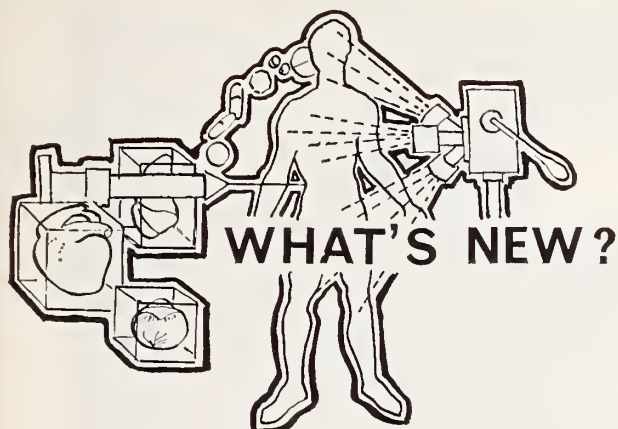
- Authorizes direct admission to nursing homes, at V.A. expense, of veterans requiring nursing home care for service-connected disabilities as stated by a V.A. physician.

- Specifically authorizes V.A. outpatient care for all disabilities for veterans with service-connected disabilities rated 80% or more disabling.

- Provides for the National Academy of Sciences to study the staffing of the V.A. hospitals and report on this subject.

- Extends V.A. mental health service to the families of veterans when it is related to the mental health or rehabilitation of an eligible veteran.





Roche announces a new preparation for the treatment of chronic urinary tract infections: BACTRIM (TM). Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole. The combination provides a double blockade action against bacterial growth, and there is evidence that, in vitro, the combination is more potent than either component.

\* \* \*

Doubleday has published "The Low Blood Sugar Cookbook" for use by the patient on a high-protein, no-sugar, low carbohydrate diet for hypoglycemia. Besides 800 plus kitchen-tested recipes the book contains advice on how to change eating habits. Special sections on entertaining at home, ordering in restaurants, feeding hypoglycemic children, holiday menus and emergency snacks. Price—\$8.95.

\* \* \*

Squibb is introducing a new single-dose, oral antibiotic treatment for gonorrhea. Each PRINCIPEN with PROBENECID PAK is supplied with seven PRINCIPEN '500' Capsules with two 500 mg. probenecid tablets. The preferred oral treatment as recommended by the Public Health Service calls for 3.5 Gm. ampicillin and 1 Gm. of probenecid administered simultaneously.

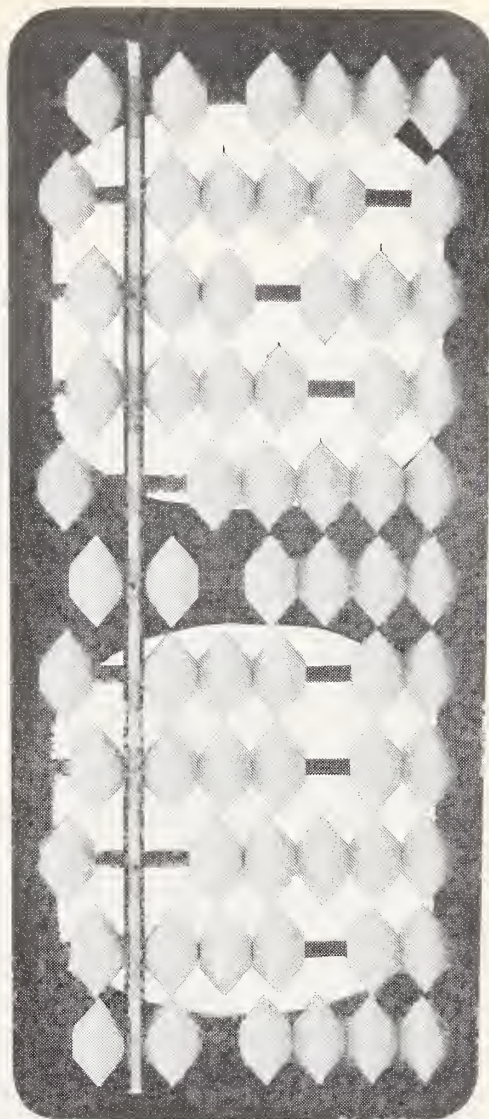
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A specially developed blood freezing bag suitable for the High glycerol red cell freezing process is being introduced by Union Carbide. Fabricated from a polyolefin film, the new bag has demonstrated lowered hemolysis and does not contain plasticizers which leach into the blood. It does not become brittle when stored at minus 80 Centigrade for prolonged periods of time.

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Syntex announces TOPSYN Gel, a topical steroid for the relief of inflammation and itching caused by psoriasis. The non-greasy gel contains the active compound fluocinonide in a transparent base which is cosmetically pleasing and does not soil clothing.

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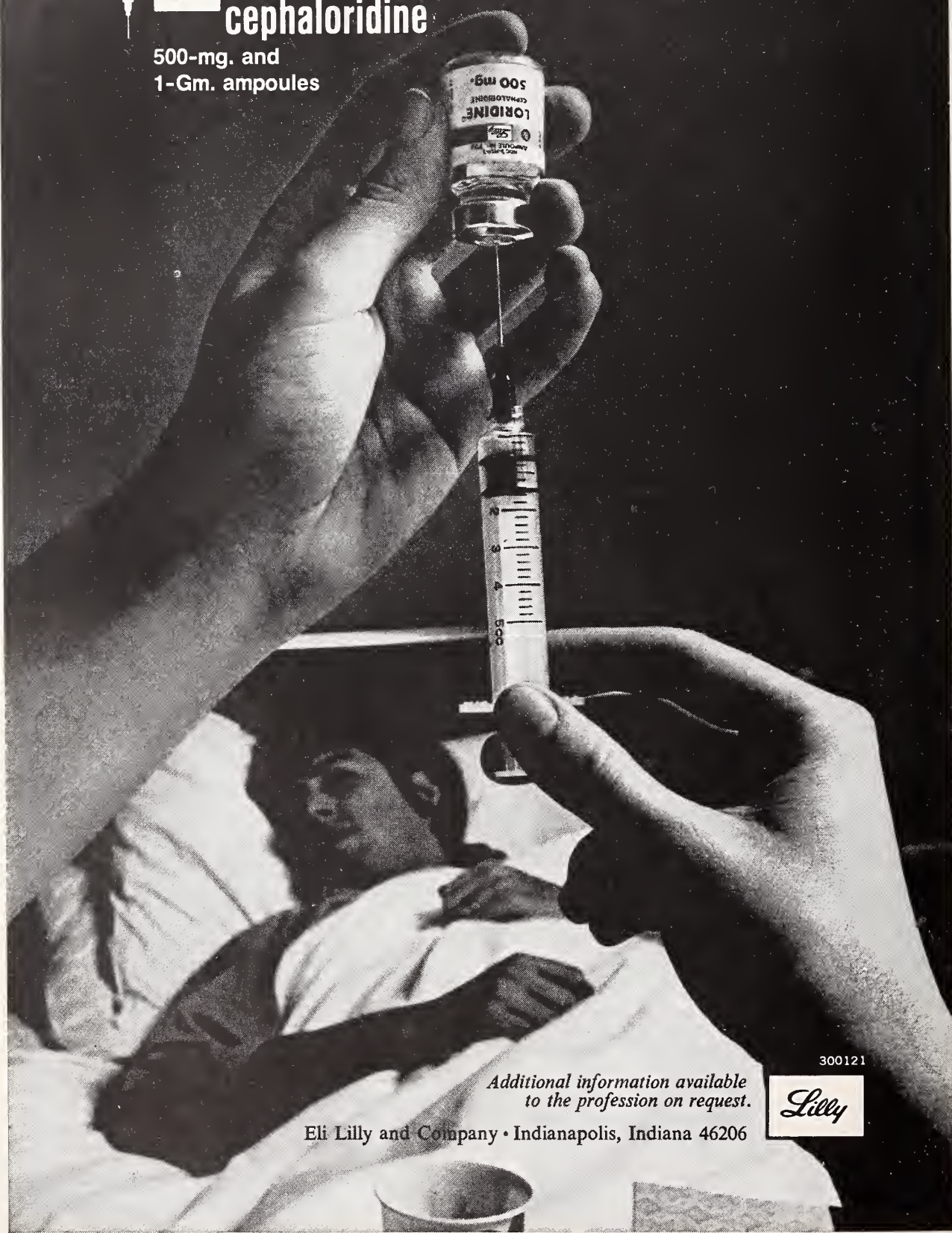
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## Angiography of the Parathyroids in Primary Hyperparathyroidism

HEUN Y. YUNE, M.D.  
Indianapolis

### Introduction

PRIOR to 1954, the radiologist's contribution in diagnosis of hyperparathyroidism was limited to the detection of demineralization of the skeletal structures and demonstration of high incidence of calculus formation in the urinary tract. Positive observations of this nature at their best were only suggestive signs of the presence of hyperparathyroidism. In very rare instances, when the size of the adenoma of the parathyroid gland was so large as to impress upon adjacent structures, it could be seen as an indentation on the tracheal air column or on a barium-opacified esophagus. In 1953, Seldinger introduced the modern arteriographic technique, and the next year he reported his

own experience in the arteriographic study of six suspected parathyroid adenoma patients.<sup>6</sup>

With the advent of further refinements in the technique of angiography, particularly selective angiography, it became apparent that the radiologist's role was more definitive. It is now widely recognized that at least 60% of all parathyroid adenomas can be accurately demonstrated preoperatively by arteriography.<sup>1,2,3,4,6</sup> A more gratifying effect of this development is the fact that these adenomas can be detected very early when they are still very small in size, and long before the full-blown picture of hyperparathyroidism appears in the skeletal system or elsewhere.

### Material and Methods

From January to September 1972, we at the Indiana University Medical Center have had opportunities to study radiologically 12 patients in whom endocrinologic

workup has suggested the possible diagnosis of primary hyperparathyroidism, and our experience in the study of these 12 patients forms the basis of this report. All patients had skeletal survey films, including the rib cage, the thoracolumbar spine, the pelvis, the skull, and the hand radiographs. On all patients, at least a plane survey radiograph of the abdomen was made, and on those who had urinary tract calculus, an intravenous pyelogram was also obtained. A thyrocervical arteriogram was performed on all of them using a selective catheter\* percutaneous transfemoral approach unless contraindicated. In the majority of cases, both thyrocervical trunks were accessible from the single transfemoral catheterization. In a couple of patients in whom the femoral pulses were weak or excessively tortuous arteries, and in one young female who was in the first

From the Department of Radiology, Indiana University Medical Center, 1100 West Michigan Street, Indianapolis 46202.

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\*Torcon Femoral-Cerebral "Headhunter" Catheters (Radiopaque polyethylene with torque control body reinforcement): Cook, Inc., P.O. Box 489, Bloomington, Indiana 47401.



trimester of pregnancy (Case 10), bilateral transaxillary catheterization was carried out. A brief summary of their clinical data is presented in Table 1.

Arteriographic Technic

The tip of the selective catheter mentioned earlier was placed immediately distal to the vertebral artery. In every case attempts were made to subselect the thyrocervical trunk and, if possible, the inferior thyroid artery. This subselection was not always possible. Because of the proximity of the vertebral artery, we have elected to use meglumine iothalamate, 60% solution,\*\* rather than sodium salts of

\*\*Conray (Meglumine Iothalamate Injection, U.S.P. 60%): Mallinckrodt Pharmaceuticals, St. Louis, Mo. 63160.

iodine. The contrast dosage and the rate of injection depended upon the location of the catheter tip; 3-4 cc if the catheter tip was in the inferior thyroid artery itself, and about 6 cc if it was in the thyrocervical trunk, injected manually in about one second. If the catheter tip could not be introduced into these branches, a subclavian arteriogram was obtained, with 15 cc of the contrast material delivered by mechanical injector immediately beyond the vertebral artery take-off at a 10-12 cc per second pressure rate. Two injections were made on each side; one in anteroposterior projection and the other in oblique (ipsilateral side down) projection. The serigraphic filming sequence was two per second for the first two seconds, one per second for the next four

seconds, then one every other second for four more seconds.

Results

Table 2 is a summary of the results of radiographic studies and the surgical-pathological findings.

(1) Arteriography.

The "blushing" of a circumscribed area within or adjacent to the thyroid gland was noted in 11 of the 12 patients studied. Ten of these were operated. Arteriographic localization of the lesion was accurate in six out of seven solitary adenomas. The size of each of these adenomas also correlated very closely. In the seventh case, the arteriographic observation was that of the left upper and lower blushing nodules, but surgically only the left upper adenoma was confirmed. In

TABLE 1  
Summary of Clinical Data

CASE	HISTORY AND SYMPTOMS	LAB DATA
1. C.A. 64WF	Weakness (10 years), left parathyroid adenoma (removed in 1964).	Serum Ca++ 12.0 (Average)
2. C.B. 58WM	Fatigability, dizziness, ASCVD & CVA. Diabetes (several years).	Serum Ca++ 11.7 — 13.3 Serum P+ 2.5 — 4.5
3. W.C. 53WM	Headache, hypertension (one year).	Serum Ca++ 13.6 — 14.7
4. D.C. 48WF	Fatigability (2 years), F.H. of parathyroid adenoma (2 cousins), insulinoma (removed in 1968).	Serum Ca++ 11.3 (Average) Serum P+ 2.8 — 3.9
5. C.D. 49WM	Obstructive jaundice.	Serum Ca++ 12.0 — 14.1 Serum P+ 1.8 — 2.6
6. H.G. 65WF	Severe bone demineralization (11 years), 2 negative neck explorations (1966, 1968), right renal stones.	Serum Ca++ 14.0 (Average)
7. R.H. 35WM	Chronic bleeding duodenal ulcer (5 years), nephrocalcinosis.	Serum Ca++ 12.0 — 14.0
8. C.M. 27WM	Multiple renal stones (since 1966).	Serum Ca++ Normal Parathormone — Mod. Increased
9. L.S. 53WM	Chronic peptic ulcer, 10 gastroduodenal surgeries (6-7 years).	Serum Ca++ 10.5 — 13.0
10. H.T. 33WF	Post-traumatic paraplegia (15 years), recurrent urinary tract infection (x20).	Serum Ca++ 12.6 (Average)
11. D.W. 64WF	No symptoms, normal annual physical.	Serum Ca++ 11.3 (Average) Serum P+ 2.6 (Average)
12. R.W. 10WM	Renal stones (since December 1970).	Serum Ca++ 12.7 — 14.0 Parathormone — Mod. Increased



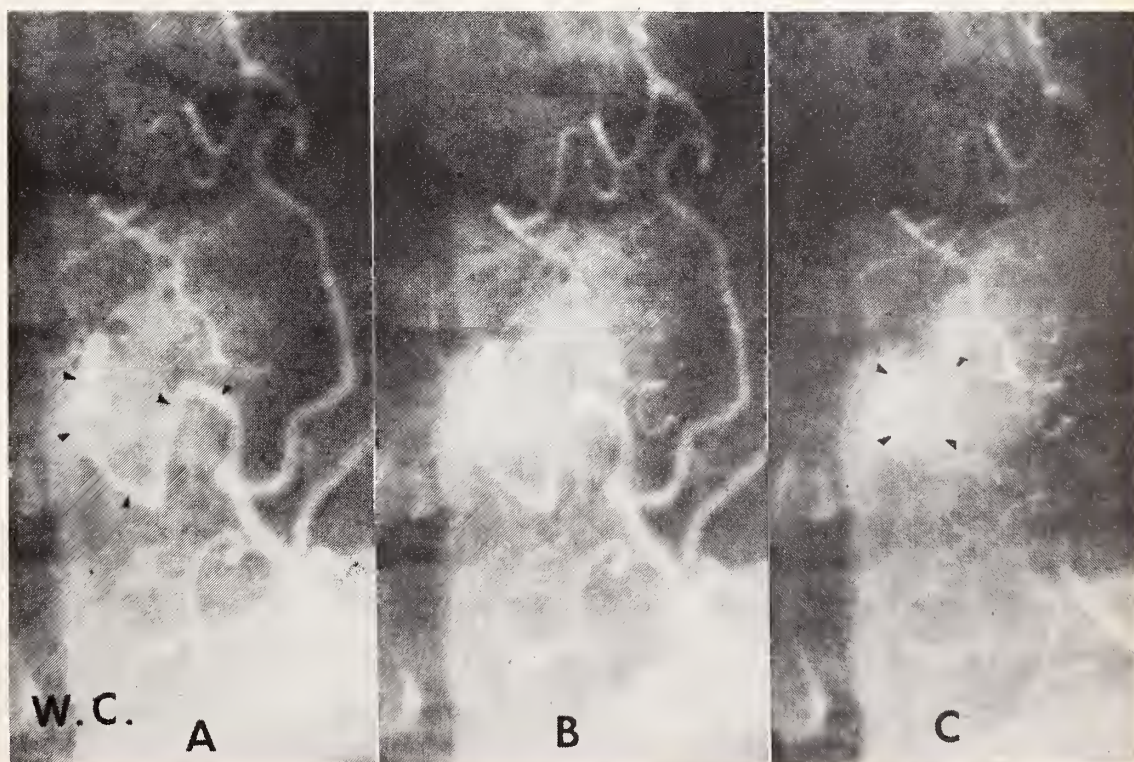
TABLE 2

## Summary of Radiographic Studies

CASE	SKELETAL SURVEY, ETC.	ARTERIOGRAPHY	SURGERY-PATHOLOGY	CORRELATION
1.	Mod. diffuse demin.	Right lower blushing (1.5 x 2.0 cm)	Right lower adenoma	True positive
2.	All negative.	Bilat. hyperplasia Rt. (2.0 x 1.2), Left (2.2 x 1.6)	No operation	?
3.	Min. diffuse demin., min. hand and skull changes.	Left lower blushing, intense (2.0 x 2.5 cm)	Left lower adenoma	True positive
4.	All negative.	Rt. upper blushing (9x15 mm) (?) of left lower blushing	3 of 4 glands removed, hyperplasia	Partial correlation
5.	(?) of hand film findings.	Left lower blushing (1.2 x 1.7 cm)	4 glands removed, prob. hyperplasia	Partial correlation
6.	Characteristic changes of bones, right renal stones.	Left lower intense blushing (1.5 x 2.5 cm)	Left lower adenoma	True positive
7.	Mod. diffuse, demin., Nephrocalcinosis.	(?) of left upper blushing	3½ glands removed, hyperplasia	Partial correlation
8.	Multiple renal stones.	Negative	No operation	?
9.	Adv. diffuse demin.	Left lower blushing (12 x 16 mm)	Left lower adenoma	True positive
10.	All negative.	Right lower blushing (1.5 x 2.5 cm)	Right lower adenoma	True positive
11.	All negative.	Right upper blushing	Right upper adenoma	True positive
12.	Mod. diffuse, demin., min. hand changes, renal stone.	Left upper and lower blushing	Left upper adenoma	Partial correlation

FIGURE 1, A, B, C

W.C., 53-year-old white male (Case 3). Early arterial to capillary phase of selective left thyrocervical arteriogram. Note prominent and tortuous branches of the inferior thyroid artery (arrows, A), which in capillary phase results in an intensely stained, circumscribed oval nodule (arrows, C) in the lower pole of the left thyroid gland. Surgically confirmed left lower parathyroid adenoma.





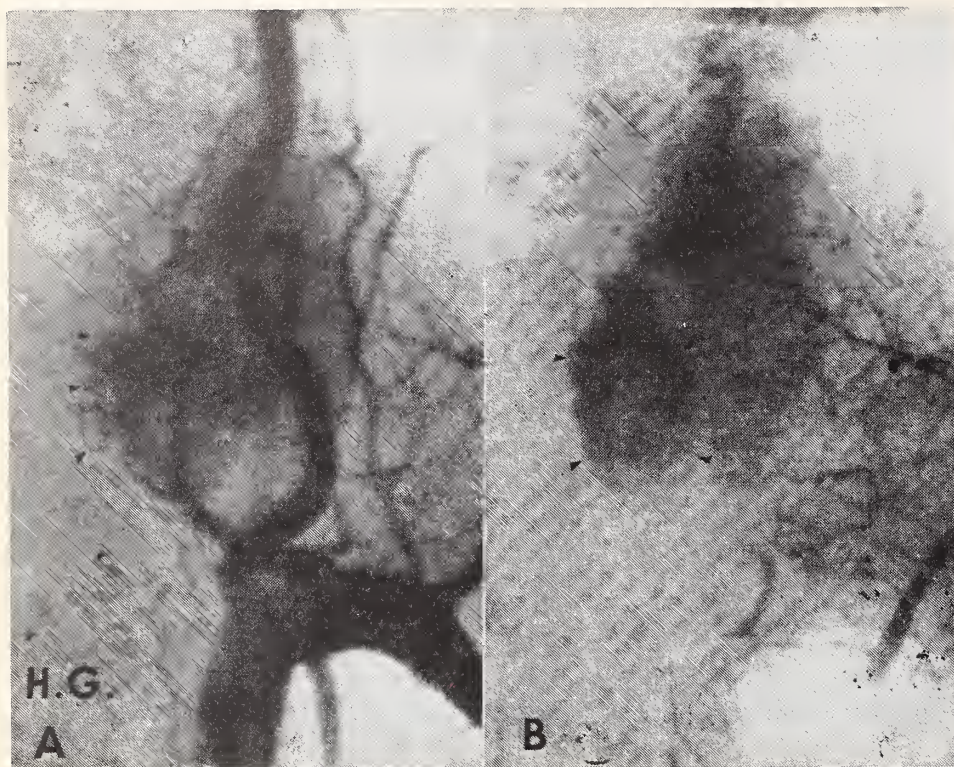


FIGURE 2, A and B

H.G., 65-year-old white female (Case 6). Arterial and capillary phase of left subclavian arteriogram on subtraction films. In AP projection the cranial loop of the inferior thyroid artery should not open laterally. This is a clear indication of a marked displacement. Terminal branches from the caudal loop are extremely tortuous (arrows, A). Note dense, clearly circumscribed nodule on the medial aspect of the lower pole of the left thyroid gland (arrows, B). For 11 years the patient was noted to have irregular areas of demineralization and atypical "sclerotic" zones in the pelvic girdle, spine, and extremities. For the latter six years she was treated under the diagnosis of Paget's disease. Bone biopsy was obtained on two occasions and the pathologist's impression was "compatible with Paget's disease." The second bone biopsy of the right femoral shaft promptly resulted in transverse fracture of the shaft, which failed to unite for six years. Because of highly suggestive endocrinologic workup, the neck was explored twice for possible parathyroid adenoma. Both were futile. The patient had had right thyroidectomy 36 years ago for hyperthyroidism and was on oral thyroid medication. Skull and hand films obtained were characteristic of hyperparathyroidism. Complications of a staghorn calculus of the right kidney necessitated right nephrectomy one year after the post-biopsy fracture of the right femur. Two previous explorations and earlier right thyroidectomy resulted in extensive scarring and the loss of tissue planes in the neck. On the third neck exploration, when the left thyroid gland was finally exposed, it was felt to be nodular—subsequently pathologically proven to be multinodular goiter. The surrounding scars and the nodular thyroid prevented identification of the left lower parathyroid. Segmental lower pole left thyroid resection was carried out. On its posterior medial surface, imbedded in the thyroid tissue, a 1.5 x 2.5 cm left lower parathyroid adenoma was discovered by sectioning the specimen. Post-operatively the serum calcium level dipped down to below 7 for a brief period and subsequently returned to  $9 \pm 0.5$  level under medication.

seven adenomas, therefore, there were 6 true positive correlations and one partially positive. Three other operated cases were hyperplasia patients. In these, only partial correlation can be made, in that the "blushing" nodules were apparently large glands rendered more readily visible by arteriography, probably because of their size. The smaller glands, although still hyperplastic microscopically, could not be distinguished within the contrast

stained thyroid shadow. The degree and time of appearance of the "blush" of the adenomas were variable. In three of these cases, the early and intense "blushing" was considered to be good evidence for the diagnosis of parathyroid adenoma (Figs. 1 and 2). In others, the "blushing" nodule was no denser than the surrounding thyroid parenchyma, but it was slightly out of phase, i.e., the staining was either slightly earlier or more prolonged.

This helped to distinguish the parathyroid adenoma from the normal thyroid parenchyma. In this latter situation, a subtraction film was very helpful (Figs. 3 and 4).

Derangement of the characteristic cranial and caudal loops of the inferior thyroid artery,<sup>3,4</sup> when associated with prominence and tortuosity of its terminal branches, was a more dependable sign of adenomatous glands (Figs. 1 and 2). Widening and stretching only of the cranial or caudal loop were not reliable criteria. Some adenomas were noted to tighten rather than stretch these loops (Cases 1 and 9).  
(2) *Skeletal Survey and Other Radiologic Studies.*

A characteristic subperiosteal cortical bone resorption of the phalanges was noted on hand films of only one patient. The skull and the remainder of the skeletal survey were also distinctly abnormal in this case (Case 6). On three other cases (Cases 3, 5, 12), there were borderline or questionable changes on hand films. Minimal to advanced diffuse demineralization of the bones on skeletal survey was noted in five other cases (Cases 1, 3, 7, 9, 12). Nephrocalcinosis or urinary tract calculus was noted in three cases (Cases 6, 7, 12). None of the cases was found to demonstrate readily recognizable tracheal indentation on routine chest or rib cage radiographs that included the neck.

## Discussion

Earlier investigators reporting on their experience with arteriography in parathyroid adenomas<sup>3,4</sup> emphasized the deranged course of the cranial and caudal loops of the inferior thyroid artery. Although this is a readily recognizable feature in very large adenomas, it is absent when the mass is small. In at least two of our cases the loop juxtaposed to the adenoma was more tightly turned than stretched and splayed.



This may be due to displacement of one limb of the loop in the direction of the other limb, resulting in a tight appearance of the loop. An adenoma will not necessarily always be in the middle of the loop. "Staining" or "blushing" of the adenoma on arteriography has been reported by more recent investigators, and is considered to be a more helpful sign.<sup>1,2</sup> It must be re-emphasized, however, that such "blushing" of adenomas vary considerably in intensity, and although some of them are very dense and readily recognizable, others require careful scrutiny and further technical manipulations. These include subtraction films which will eliminate the obscuring background bone shadows, and a preliminary thyroid scan. In current series, we were able to make the diagnosis of adenoma on direct positive radiographs on three instances. In the others, our final diagnosis relied heavily on observations made on subtraction films. On three occasions we would have missed the lesion without subtraction films. Most recently, Kuntz and Goldsmith<sup>2</sup> have combined arteriography and the direct thyroid scan to facilitate identification of the area of stain produced by the parathyroid adenoma. This is basically a very sound idea and its value is amply demonstrated in their study of 15 solitary adenomas. Twelve of these adenomas were accurately localized and the size estimated. As is indicated in their report, multiple adenomas or hyperplastic glands will be hard to identify even with this combined technique. In our series, we have attempted to utilize the thyroid scan to complement the arteriographic observations, but in about half of those who had thyroid scans, the scan did not serve any useful purpose because the results of the radioisotope thyroid scan were misleading in hyperplastic glands, upper parathyroid adenomas, an intrathyroid parathyroid adenoma imbedded within a multinodular goiter

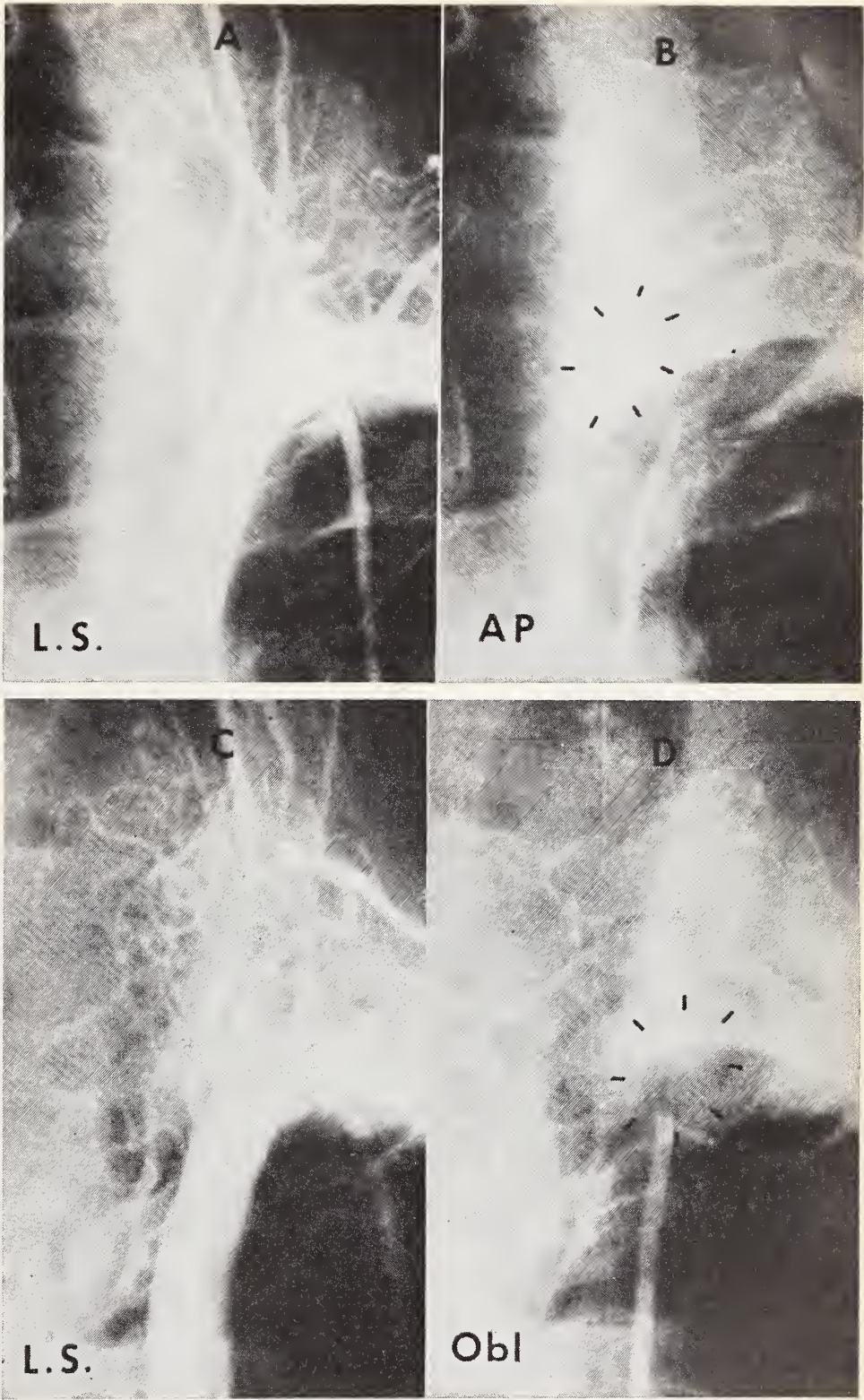


FIGURE 3, A, B, C, D

L.S., 53-year-old white male (Case 9). Left subclavian arteriogram in AP (A and B) and oblique (C and D) views. Inferior thyroid artery is in normal position. Faint but well circumscribed stain is noted in the lower pole of the left thyroid (B and D).

(Case 6), and a patient who had a previous parathyroid surgery (Case 1). Other more recent methods of identification of adenomas include retrograde thyroid venogram,<sup>7</sup> which is less reliable than the arteriogram

because of much wider anatomical variation in the venous network draining the thyroid and parathyroid glands, and the multiple thyroid venous sampling for parathormone assay,<sup>5</sup> which is very time-consum-



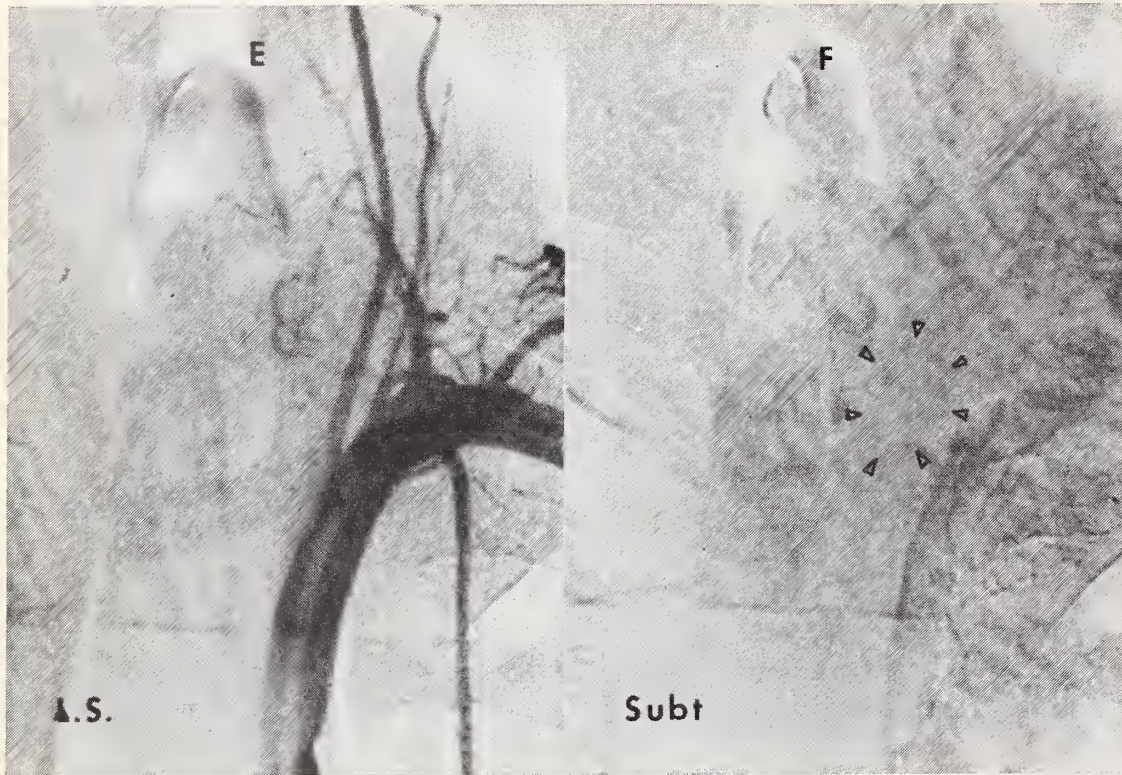


FIGURE 3, E and F

SUBTRACTION series of A and B demonstrates this discrete nodule (arrows, F) more clearly. Note the intensity of this "blushing" is scarcely denser than the surrounding thyroid tissues.

ing and requires a laboratory equipped to do such an assay.

Even when such sophisticated equipment is not available, a radiologist with some experience in the technique of selective arteriography can contribute significantly and quickly in identifying and localizing adenomas of the parathyroid gland by performing selective thyrocervical arteriography.

### Summary

The selective arteriography of the thyrocervical artery is now utilized in accurate localization and determination of size of adenomas of the parathyroid glands. Our experience confirms the result of recent investigators. True positive correlation was obtained in six out of seven solitary adenomas in current series. It is felt desirable but not mandatory to have the selective catheter tip enter the thyrocervical trunk for subselection of the inferior thyroid artery. When such subselective visualization is technically difficult, increased volume and faster rate of injection of the contrast material into the subclavian artery immediately beyond

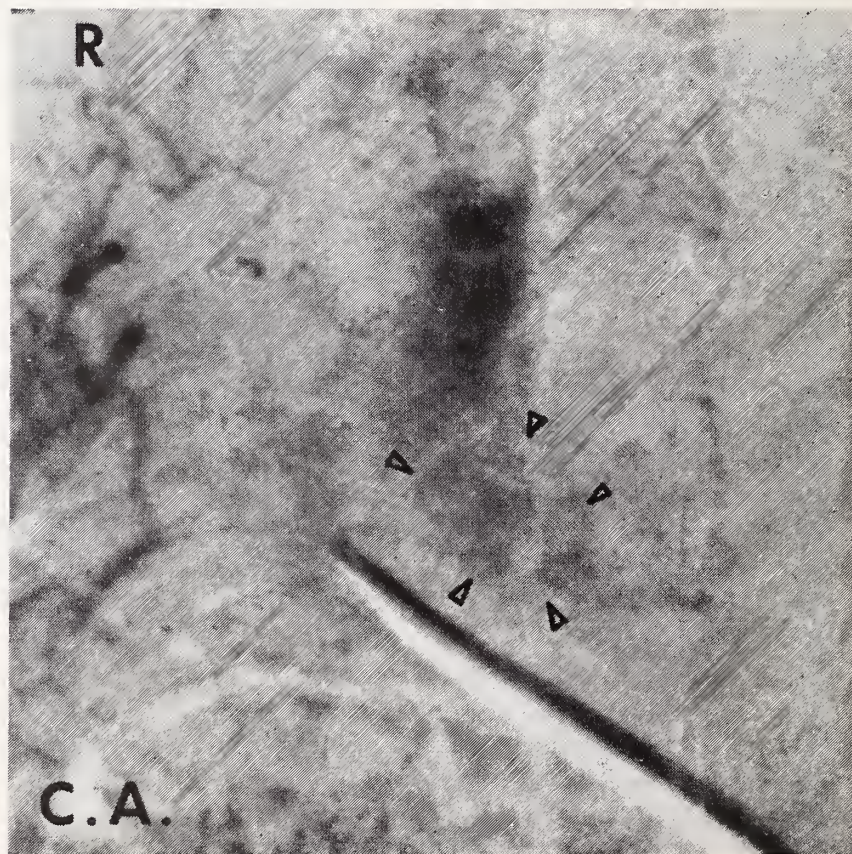


FIGURE 4

C.A., 64-year-old white female (Case 1).

FAINT blush of the right lower parathyroid adenoma demonstrated only on a subtraction film of a capillary phase of the right subclavian arteriogram. The thyroid stain is in fact denser, but the parathyroid nodule is fairly well circumscribed.



the origin of the vertebral artery has served the purpose adequately. Safer contrast material now available makes this possible. The "blushing" of the parathyroid adenoma demonstrated on arteriography is widely variable as to its intensity and the time of appearance, and, for this reason, routine use of the subtraction technique is helpful.

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Erratum

In the article in the August issue titled "A Practical Approach to Chemotherapy of Disseminated Breast Carcinoma," there is an error in Table 10 on page 721. The dosage for Oncovin should have read: .035 mg/kg/wk.



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# Successive Manifestations of Tuberculosis in a Recalcitrant Patient

MORGAN E. GREENE, M.D.  
ROBERT B. STONEHILL, M.D.  
Indianapolis

It is well recognized that pulmonary tuberculosis is a chronic progressive infection which requires adequate, persistent, long-term chemotherapy to achieve favorable results. The ability of the organism to remain viable within the body is well known, and exacerbations after inadequate therapy are common. As patient cooperation is of paramount importance, the uncooperative patient poses a therapeutic challenge of staggering dimensions. We feel that the case which we present demonstrates not only this problem, but also a spectrum of disease not usually seen in one individual.

## Case Report

A 34-year-old negro male was admitted to the Pulmonary Disease Service of Marion County General Hospital on July 10, 1967, with complaints of chest pain, a non-productive cough, dyspnea, anorexia and a weight loss of eight pounds. His x-ray showed a homogeneous opacity of the entire left lung with the mediastinum shifted to the right (Fig. 1). Upon admission, a thoracentesis was performed. When 50 cc of fluid was obtained, the patient fainted and the procedure was discontinued. Laboratory analysis of the fluid indicated that it was an exudate. The patient had a

positive intermediate P.P.D. skin test with 24 mm induration. The patient left the hospital against medical advice before any definitive therapy could be initiated. A diagnosis of probable tuberculous pleurisy with effusion was made.

The patient sought no medical treatment until February 3, 1969. He stated he had the "flu" in December 1968, and had not recovered from it. He had marked shortness of breath, considerable weakness, anorexia, vomiting, a 30 pound weight loss, chills, profuse sweating, and a cough productive of yellow sputum. His chest x-ray showed some pleuritic involvement in the costophrenic angle on the left side where the massive effusion had been, and miliary lesions

throughout both lung fields (Fig. 2).

Because the patient was in critical condition and toxic, he was started on 60 mg of prednisone daily as well as isoniazid, para-amino-salicylic acid and daily streptomycin. The patient had positive sputum on smear and culture for typical acid-fast bacilli. He improved clinically and x-rays showed his condition had improved. While still receiving 45 mg of prednisone daily, he left against medical advice on February 23, 1969.

The patient returned again March 3, 1969. He was re-admitted and treated with isoniazid, Rezipas, streptomycin and prednisone. His wife, from whom he had been separated much of the time, was likewise



FIGURE 1  
LEFT pleural effusion.

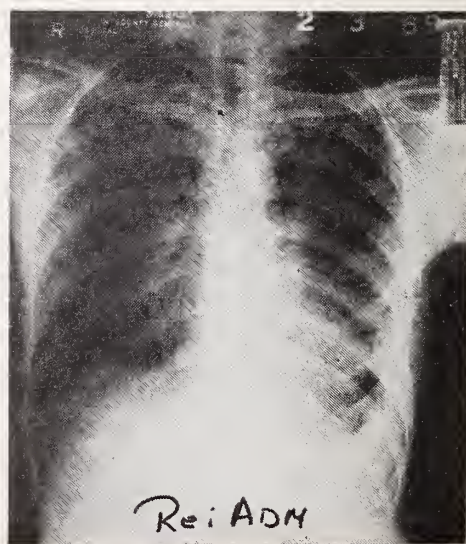


FIGURE 2  
MILIARY distribution of tuberculosis.

From the Pulmonary Disease Service, Marion County General Hospital, 960 Locke St., Indianapolis 46202.



admitted and treated for tuberculosis at that time. The patient again left the hospital against advice and was discharged May 1, 1969. He was reported to the Tuberculosis Control Office of the Division of Public Health. A warrant for appearing in public with a contagious disease was issued May 3, 1969.

The patient eluded the police and apparently was out of town much of the time. He reported to the hospital August 26, 1969, and again was started on isoniazid, para-aminosalicylic acid, and streptomycin. Since he was under therapy, the warrant was not served, but trust was ill-founded and he again left against medical advice September 5, 1969. Sputum collected during that hospitalization, however, was negative on smear and culture.

The patient next showed up in Pulmonary Disease Clinic January 7, 1970. His x-ray revealed improvement, and though he was followed subsequently somewhat irregularly, he was kept on isoniazid and did relatively well until August 19, 1971, when x-rays indicated progression of the disease.

His fifth admission was from August 25, 1971, to September 3, 1971, when he again left against advice. Two smears and four cultures were positive for typical acid-fast bacilli during that admission.

He was admitted to the detention ward December 14, 1971, on a contagious disease warrant issued September 20, 1971. He was treated with isoniazid, pyrazinamide and Seromycin. He denied any symptoms. His chest x-ray showed a small cavity in the left first anterior interspace (Fig. 3). Sputums were consistently negative on smear and culture. The patient's quarantine was released March 7, 1972. He signed his own release and left the open ward March 12, 1972. His disease at that time was considered inactive 0 months.

## Discussion

This case amply demonstrates that the spontaneous resolution of a pleural effusion in a patient with a positive tuberculin skin test does not rule out tuberculosis as the etiologic agent causing the effusion. There is a high incidence of the subsequent development of other forms of tuberculosis in a patient with untreated tuberculous pleurisy with effusion. Pättälä reported that 43% of 2816 Finnish soldiers with serofibrinous pleuritis developed other signs of tuberculosis during a follow-up period of seven to nine years.<sup>1</sup> Roper et al. reported on 141 American soldiers who were followed for five years after developing a serofibrinous pleural effusion.<sup>2</sup> All cases had a positive intermediate P.P.D. skin test. Of the 141 cases, 65.2% developed other manifestations of tuberculosis. These recurrences included both pulmonary and extrathoracic tuberculosis.

It is ideal to isolate the mycobacterium in all cases of tuberculous pleurisy with effusion. However, examination of the sputum, pleural effusion, and even needle biopsy specimens of the pleura frequently fail to reveal positive acid-fast smears or culture of the organism. Thus, it is now accepted practice to treat all cases of serofibrinous pleural effusion with a positive intermediate P.P.D. skin test where other causes of the effusion cannot be determined. Treatment consists of two effective first line drugs. Either ethambutol or para-aminosalicylic acid is used with isoniazid. This regimen should be continued for at least 18 months after disappearance of the effusion where underlying pulmonary tuberculosis is not evident. When there is pulmonary tuberculosis, drug therapy should be continued at least 18 months after the disease has become quiescent.

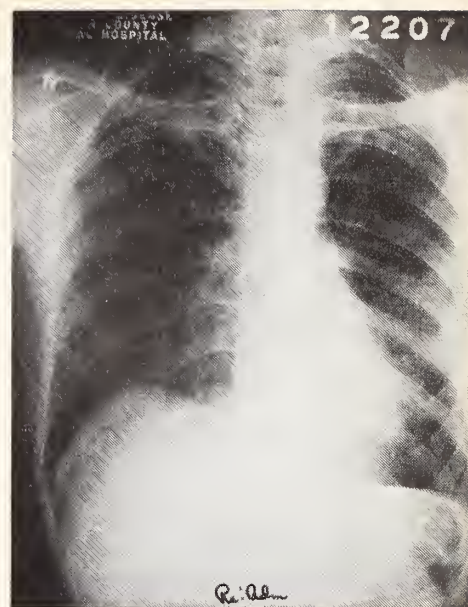


FIGURE 3  
LESION in first interspace of left chest.

Our patient developed both pulmonary and acute miliary tuberculosis subsequent to his untreated pleural effusion. Acute miliary tuberculosis is a highly dangerous form of the disease, thought to be almost uniformly fatal without adequate chemotherapy. Much to our surprise, the patient overcame his miliary disease on a grossly inadequate treatment in terms of duration of therapy.

In treating acute miliary tuberculosis, one should use three effective first line drugs for a minimum of two years after remission of the acute infection. Those having a high potency with relatively low toxicity are isoniazid, ethambutol, para-aminosalicylic acid, rifampin and streptomycin. When the patient is desperately ill, corticosteroids can also be utilized early in the treatment for non-specific antipyretic and anti-anorectic effects. However, they should be used only under the cover of adequate antituberculous chemotherapy.

Unfortunately, the occasional patient with pulmonary tuberculosis shows no understanding of his problem and no public responsibility. He either refuses to receive treatment or to be treated beyond the



period of immediate personal concern for which he sought medical advice. When, with a positive sputum, he forsakes treatment, he remains a public health hazard. The physician may have to resort to the agencies of the law to protect public health when rapport, reasoning and logic fail. In Indiana the state law allows for the quarantine of any person suspected of having a contagious disease and who is found in or is known to present himself in a public place. This quarantine is initiated by a public health officer. The offender is arrested and brought before a court. The judge may then order him confined to a hospital or otherwise isolated until it is ascertained that he does or does

not have an infectious state.

Once it is determined that the patient is contagious, the law provides that the health officer may pursue commitment proceedings, whereby a court may commit the individual for hospitalization, care and treatment. In counties not having a hospital with facilities to handle tuberculosis patients properly, commitments may be made to any hospital within the state with such capabilities.

Thus, the irresponsible patient with pulmonary tuberculosis can be isolated while in the contagious state. Unfortunately, the law does not provide for enforced care once the patient's sputum tests have become negative for acid-fast bacilli

on smear and culture. In optimum care, treatment must be continued for months or years beyond this point, usually on an outpatient basis. If treatment is terminated too early, the breakdown rate of tuberculosis is considerable, and the prospect of future contagion with a partially resistant organism is formidable.

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665 East 61st Street Telephone: 317-255-6525

Mailing Address: P.O. Box 20132, Indianapolis 46220



## *Indiana Frontiers in Medical Education*

JOE ROBERTSON, JR.  
Brownstown

**M**EDICAL education is concerned with the transmission and further development of knowledge of the medical sciences. It must strive to improve the professional skills of the practice of medicine and institute the application of these skills to the needs of society. Modern medicine, like civilization as we now know it, could not exist without the accumulation of a vast body of reliable information regarding the health and diseases of human beings.

Any realistic study of the history of medical education must consider those purposes and ideals which have inspired and influenced its former development. Changing social, economic, scientific and professional conditions will largely determine the course of its future development. A reasonable anticipation of the future, aided by a reflection on history, is necessary if future medical educational programs which are practical yet enlightened are to become a reality.<sup>1</sup>

Medical education has played an integral role in the social history of America. The physician, a man trained to relieve suffering and to combat death, is one of society's essential components. History has set this man apart to render a service for which there has always been an urgent human need.

Because of the effect of his medical education upon the physician, it is of interest to trace the advances and setbacks of this education. This paper will explore the subject from

the days of the American pioneers and the era of the great Western expansion, through the initial emergence of medical science, and up to the present time. Because of the tremendous scope of this subject, the history of medical education in Indiana will be used as a geographically limited example of this development.

The story of the organization and development of medical education in the United States and in Indiana begins with the preceptorial system which continued with modification well into the last half of the nineteenth century and was very good or very poor, according to the character and ability of the preceptor.

The preceptorial system was simple. Students were apprenticed to their preceptors (practicing physicians) for three or four years. The students usually lived in the home of their instructors and often performed menial household and stable chores. The knights of the scalpel were expected to learn to make pills and potions, visit patients with the doctors, cup, bleed, do bedside nursing, help in the office, and read whatever medical books were available. During this period there were no legal restrictions upon medical practice, so the aspiring "doctors" entered practice on their own whenever they or their preceptor decided that they were properly prepared. The preceptor often issued a "diploma" when the student "graduated."<sup>2</sup>

There were great variations in the

qualifications of students beginning study. Perhaps the most general requirement was a knowledge of the classical languages, especially Latin, if not at the beginning, at least before the termination of study. Other subjects often regarded as fundamental were mathematics, English grammar, and natural history. However, the general state of ignorance among the profession, especially in rural districts, provides sufficient evidence to indicate that many a young man began his practice without any liberal education worthy of mention.<sup>3</sup>

The usual annual fee paid by the student was \$100. For this fee the preceptor furnished instruction, books, and other useful materials. Those more fortunate students also received a skeleton in their package deal. Cadavers were in actuality non-existent for anatomical dissection. "Autopsies" were performed on occasion but few of these were of a scientific nature.<sup>4</sup>

During the first 40 years of the nineteenth century most of the doctors in Indiana were trained by study under preceptors. An example of how excellent this training could be is provided by Dr. David H. Maxwell, the first president of the Board of Trustees of Indiana University. He had as his preceptor Dr. Ephraim McDowell of Kentucky, the man who performed the first ovariectomy in America.<sup>5</sup>

Unfortunately, this type of training could be very poor, as indicated



by the following excerpts from an advertisement in the Richmond (Indiana) *Palladium* of January 8, 1831:

#### DR. WILLIAM LINDSEY

. . . informs the public generally that he now considers himself permanently located in the town of Richmond, Indiana. In the practice of his profession, in the branches of PHYSIC, SURGERY and MIDWIFERY . . . He still keeps on hand a general assortment of Drugs and Medicines, including PAINTS AND DYESTUFFS, all of which he offers low for cash . . .

Likewise prepares (himself) an oleaginous Blacking, which renders leather water proof. And can with confidence recommend it to the public as preservative of leather, superior to anything of the kind he has seen. Tanners, Shoemakers, Harnessmakers, and all others who wish to keep their feet dry, should do well to call and examine the article.

A few young men who are qualified, will be taken as medical students.<sup>6</sup>

The claim is often made that the students of the preceptorial system were not inclined to be theorists. Although they were often ill prepared, the practical clinical observation and experience which these students encountered from the beginning of their study built into the American medical profession a spirit of self-confidence which has continued to exist until the present. However, this virtue has often been considered a vice by critics. They profess that this "virtue" has led some physicians to work with zeal but without knowledge. When evaluating the preceptorial system, it is important to realize that this early plan of medical education was

not only well adapted to the unpolished state of a pioneer society, but also was, to some extent, the product of a wilderness culture which nurtured that society.<sup>7</sup>

There was one important stage of progress which linked the preceptorial system with the opening of medical schools. This development included systematic schedules of lecture and demonstration courses which were presented to a group of students. The subject normally covered was anatomy.<sup>8</sup>

As population centers developed, certain doctors were recognized for their particular ability in specialized fields of medicine. It soon became obvious that a group of doctors, each representing some special field of medicine, could do a much better job of medical training than any one of them could do alone. From this concept the first medical schools began to evolve.<sup>9</sup>

Even after medical schools were established, the preceptorial system remained as an integral part of medical education. A candidate for the M.D. degree was generally required to study under a preceptor for three years in addition to his attendance at certain lecture courses for either a term or a year, depending upon the circumstances. Thus, the apprentice system, with both its vices and virtues, was perpetuated.<sup>10</sup>

A high mortality rate plagued most early pioneer medical colleges. The usual causes were poor financing and inexperienced faculties. But the complication which finally brought an untimely death to these early institutions, whose auspicious beginnings had been hailed with elation, was the fact that these early doctors were individualists. Because of their lack of experience or training in teamwork, they were unable to attain the collaboration necessary for the successful maintenance of a medical school. Whenever trouble, dissension or discord developed, the college soon ceased

to function. Often the faculty divided and formed two new schools, each of which would probably soon experience similar troubles.<sup>11</sup>

Twenty-four colleges of medicine were chartered in Indiana from 1806 to 1906. There are too many to study each individually. A general survey does, however, tend to indicate the great length and ardors of the trail from the early Indiana campground and lodge of the medicine man to the area where Indiana (Land of Indians) men of medicine are trained today.

The first General Assembly of the Indiana Territory in 1806 passed an act (Chapter V of the 1806 Laws) which provided for the establishment of the University of Vincennes. Section 9 of this act includes the expression of a definite purpose on the part of those early settlers to establish medical education. This clause states that the trustees "shall from time to time elect and appoint a professor of Divinity, of Law and Physic."<sup>12</sup>

As early as 1816 the legislature passed an act regulating the practice of physic and surgery. By this act a district medical society was established in each of Indiana's congressional districts. These societies selected boards of censors to examine and license candidates who desired to practice in Indiana. In 1820 representatives from these districts formed the State Medical Society.<sup>13</sup>

During the first half of the nineteenth century medical education sank to a low level. The great Western expansion demanded an increase in the number of physicians but the waves of immigrants flooding into the country contained only a few highly educated people. The low ebb in medical training resulted, in a large measure, from the hasty establishment of a great many medical schools by frontier doctors. Many communities, no larger than



villages, decided that their geographic location was an ideal spot for a medical school. This situation prompted a veritable rash of medical colleges which could be characterized as "an enlightening exhibition of the life and work of professional men, undisciplined within and unregulated without, while they attempted to give medical care to a rapidly expanding democracy in which ingenuity was unhampered and personal liberty was glorified."<sup>14</sup>

The multiplicity of unregulated schools could not avoid shattering educational standards. A lack of endowments, coupled with excess commercialism and intense rivalry, all contributed to this degradation. The success of a school, as well as reputation and especially financial return for instructors, was often determined by the number of students who could be attracted by hook or by crook. The competition for students often led to publication of extravagant and misleading statements. Facilities for clinical teaching were virtually nonexistent.<sup>15</sup>

One of the greatest problems encountered by these early medical schools was the procurement of bodies for dissection. This was an ancient medical problem which had been solved in England by legalizing the use of unclaimed bodies for anatomical study. The following words, penned by Robert Louis Stevenson, might just as easily have described a similar episode in this country long after such incidents had been eliminated in England:

"The Resurrection Man—to use a by-name of the period—was not to be deterred by any of the sanctities of customary piety. It was part of his trade to despise and desecrate the scrolls and trumpets of old tombs, the paths worn by the feet of worshippers and mourners, and the offerings and the inscriptions of bereaved affection. To rustic neighbourhoods where love is more than

commonly tenacious, and where some bonds of blood or fellowship unite the entire society of a parish, the body snatcher, far from being repelled by natural respect, was attracted to the ease and safety of the task. To bodies that had been laid in earth, in joyful expectation of a far different awakening, there came that hasty, lamp-lit, terror-haunted resurrection of the spade and mattock. The coffin was forced, the

cerements torn, and the melancholy relics, clad in sackcloth, after being rattled for hours on moonless byways, were at length exposed to uttermost indignities before a class of gaping boys."<sup>16</sup>

The people of those times were apparently aware of how widespread body snatching actually was. This practice was epitomized by an epitaph which Dr. W. D. Snively, Jr., discovered while preparing a history of the 1858 medical education policy and practice in Evansville:

"The body snatchers, they have come and made a snatch of me. It is very hard—they kind of men won't let a body be. Don't come to weep upon my grave and think that here I be, They haven't left an atom here of my anatomy."<sup>17</sup>

The first medical school to be founded in Indiana provides a good example of how poor these colleges could be. The Christian College at New Albany was chartered by John C. Bennett and Associates in 1833. In reality, this was no medical college at all. It granted medical degrees and diplomas under the assumed name "University of Indiana." It was a completely fraudulent arrangement and became extinct almost as quickly as it was born. No further records of its activities are available.<sup>18</sup>

From the records of La Porte University School of Medicine (1841-56), Indiana Central Medical College (1869-78) and the Medical College of Evansville (1849-54; 1874-84), we can learn more about the specific details of these early establishments. There was generally one faculty member for each department and the subjects which were taught included obstetrics, diseases of women and children, physiology, surgery, theory and practice, medical jurisprudence, chemistry, materia medica,

**UNIVERSITY OF VINCENT, Indiana**  
**Medical Department.**  
**First Course.**  
 THE lectures in this institution will commence on the first Monday in December 1837, and end on the first Monday in March 1838.  
 Special Anatomy, by **Dr. Offutt,**  
 General and Pathological Anatomy **Maddox,**  
 Surgery, **Johnston**  
 Obstetrics and diseases of women and children, **Hitt,**  
 Chemistry and Natural Philosophy, **Troost,**  
 Materia Medica and Pharmacy, **Decker,**  
 Theory and Practice of Medicine, **Somes,**  
 Physiology and Institutes of Medicine, **Stall.**  
 The price of all the tickets will be \$80.  
 Matriculation \$2. Dissecting tickets, \$5.  
 The University building is large and commodious. The town is healthy and so situated as to mark it out as a point peculiarly adapted to the location of a medical school, being on the confines of two states and easy of access. There is a large and excellent library attached to the institution, to which students will have access gratis. The faculty can also inform students that they will in all cases be entitled to the benefits arising from observing clinical practice gratuitously, and that in rare or difficult cases, great care will be taken to impress on their minds important medical and surgical information. The faculty are entitled by their charter to confer the degree of Licentiate of Medicine, an extension of which will however be applied for at the ensuing session of the Legislature, and there can be no doubt but the power to confer the degree of Doctor of Medicine will be promptly granted. Those students who may wish to stand an examination for the degree of L. M. can do so at the expiration of one course. Those who attend the ensuing course are informed that it will be considered equivalent to a full course under the anticipated extension of the charter, and that they will be admitted as candidates for the degree of M. D. by attending a second course.  
 Good boarding and lodging can be obtained at from \$2.50 to \$3.00 per week. Students upon their arriving in town, will please call upon the Dean at Col. Clark's Hotel.  
**THORNTON F. OFFUTT,**  
 Dean of the Faculty of Physicians.  
 Vincennes, Sept. 17, 1837.—17—  
 The Missouri Republican, St. Louis, Indiana Journal, Indianapolis, and Free Press, Vandalia, Illinois will publish the above weekly to the amount of \$5 each, and forward their accounts to the Board for payment.

**LARGE MAPS OF THE**  
**PUBLIC announcement of the opening of the first medical school in Indiana, 1837.**



anatomy, and eye and ear diseases. Fees varied from school to school but lecture tickets were approximately \$10 per course, a dissection ticket \$5. Matriculation and graduation fees ranged from \$5 to \$50. Board, including light and fuel, was available at \$2 weekly. The requirements for graduation were as follows:

"Each candidate for the degree of M.D. must have attained the age of 21 years and present satisfactory evidence of good moral character.

"He must have studied medicine three years and have attended two full courses of lectures, one of which must be in this institution. Four years reputable practice of medicine however, will be considered equivalent to one course of lectures.

"The candidate must deposit with the Dean of the Faculty a thesis on some branch of medicine or the collateral sciences, of

his own composition and in his own handwriting. He must also undergo a satisfactory examination before the faculty on the various branches of the profession."<sup>19</sup>

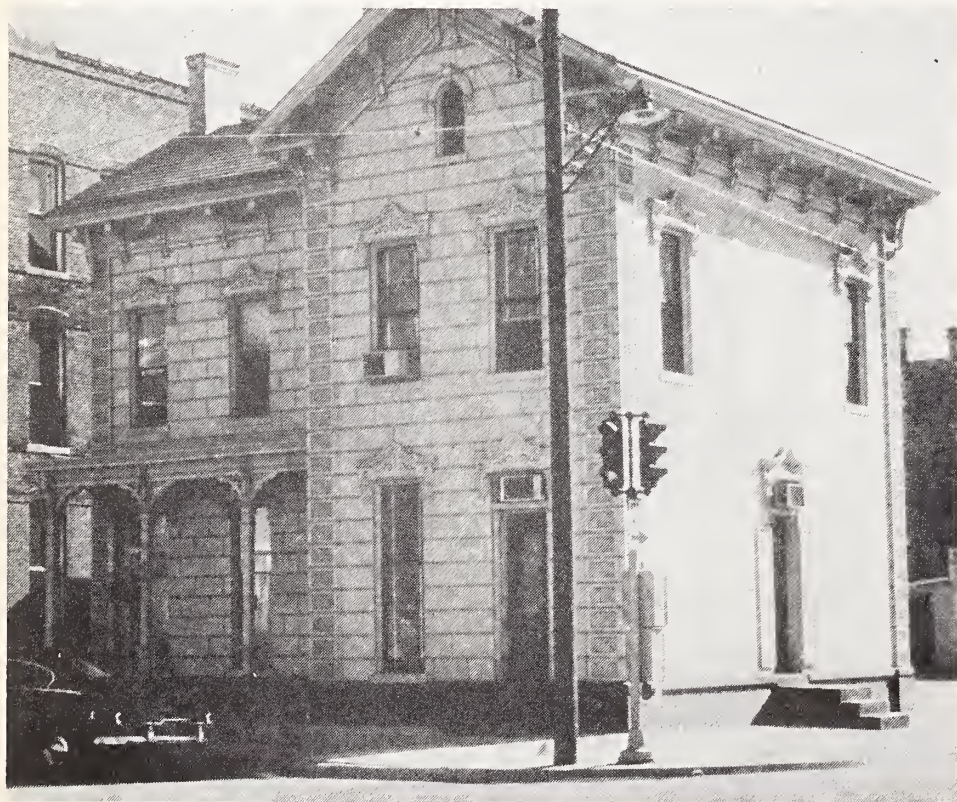
It was June 1903 when the Indiana University School of Medicine was officially founded. This was 138 years after the first American medical school was established as the College of Philadelphia, later to become the Medical Department of the University of Pennsylvania. However, it should be remembered that just as it was necessary for medical adventurers to bring their knowledge from Europe across unfriendly seas in the eighteenth century, so in the nineteenth century it was necessary for later adventurers to carry their knowledge and skills over a thousand miles of unfriendly and almost unmapped terrain to new frontiers. Actually, there is so much background in both physical and scientific development

prior to the official founding date of this Indiana medical school that the real beginning of the institution might more properly be placed in the early days of 1820 when settlers were clearing Indians and forests from a small area near the junction of Chunk-ti-nun-gi (Fall Creek) and Wa-me-ca-me-ka (White River) near the geographical center of Indiana, now Indianapolis.

Clinical training in a hospital is now considered one of the most, if not the most, important phases of medical training. However, hospital facilities were virtually non-existent in the newly formed state of Indiana (1816). Early Hoosier settlers recognized a need for hospitals, but they seemed quite lethargic about the matter when confronted with the task of actual erection of a building. Shortly after Indianapolis was laid out, two spots were set aside for health and cultural purposes. However, with the exception of a log cabin institute, the Central Hospital for the Insane (1846-47), "Hospital Square" was never used for providing health services. Numerous smallpox scares were necessary to motivate the people to construct a hospital.

In May 1830, a Negro woman by the name of Overall suddenly came down with what was diagnosed as smallpox. It was never determined from whom she contracted the disease. Vaccination, although practiced in Europe and on the Eastern Seaboard, was not yet available in the "Western Wilderness Capitol." The town was in an uproar; they appointed a board to do what they could to control the epidemic, but no significant action was taken. For some reason, the disease did not spread, and the incident was soon forgotten.<sup>20</sup>

In 1848 a death due to smallpox was again recorded. The population was ordered vaccinated and again the disease was controlled. This scare prompted some action. The



THE Medical College of Evansville, where the first lectures were given on November 5, 1849.



Board of Health purchased a piece of property for the purpose of building a smallpox hospital. A special tax to provide payment was levied and lumber was even hauled. But, again, no hospital was built. When the disease did not spread, the lumber was used for another purpose. Other scares were recorded but they never resulted in construction of a hospital. It appeared that the city would never learn.

Due largely to the efforts of Dr. Livingston Dunlap, Indianapolis finally acquired a hospital. On March 10, 1855, the City Council ordered the erection of such an institution. A final smallpox scare hastened this construction. The location chosen was the site of today's Marion County General Hospital, adjacent to the medical center. This particular tract of swampy land, near the junction of the two streams in the city, was chosen because it was believed that no one could or would want to live out there. The people of that era did not want an institution for "sick" people near the homes of "healthy" people. The land has since been drained and is now nearly surrounded by the modern metropolitan district.<sup>21</sup>

The hospital was finally finished in 1859 at a cost of about \$30,000. This was a princely sum and left no funds for furnishing and equipping it. It soon acquired the name of "Dunlap's Folly" and was eventually turned over to a group of ladies to be used as a home for friendless women—harlots. The building was used as a government hospital during the Civil War. In the spring of 1866 the city made a half-hearted attempt to furnish it and use it as a hospital. It was opened to patients on July 1 of that year. Many stories are told of the old hospital. The neighborhood was very bad, both morally and from the standpoint of good health. Hospital gangrene was a terrible affliction in those days. It was said that "the stench could be

detected for blocks." A little later, when the use of iodoform became general as an antiseptic dressing, the odor was even worse.<sup>22</sup>

During the university administration of President Cyrus Nutt (1860-1875), Indiana recognized the need for a medical school. President Nutt made an arrangement for affiliation with the Indiana Medical College at Indianapolis, whereby that medical school became the Medical Department of Indiana University. This was purely a "paper" arrangement. The University made no contribution to the income of the institution, so far away and so widely removed from the previous purposes of the University. The arrangement was discontinued in 1875 because President Lemuel Moss feared that standards were far too low and that unqualified persons might be added by that means to the list of graduates of Indiana University.<sup>23</sup>

In 1903, President William Lowe Bryan, a pioneer in experimental psychology, persuaded the trustees to found a School of Medicine. Dr. Burton Dorr Myers came to teach anatomy in September and may be said to have been the first member of the medical faculty. His job was greatly facilitated by the passage of the Anatomical Law by the Legislature of 1903 which enabled the university to obtain bodies for dissection. However, the jealousy of the established schools in Indianapolis was such that, by control of the Anatomical Board, they were able to shut off the supply, and Dr. Myers was compelled at first to use cats which had been carefully injected. The cats were in some ways better than the poorly preserved bodies commonly used in dissecting rooms at that time.<sup>24</sup>

During the years 1903 to 1906, Indiana University offered students two years of instruction in medicine. At the end of this period of

study, the student enrolled for the final two years wherever he might gain entrance. It was not a good arrangement, but it was the best possible under the circumstances.<sup>25</sup> In 1908, despite keen rivalry, The Medical College of Indiana, Central College of Physicians and Surgeons, and Fort Wayne College of Medicine united with and became integral parts of the Indiana University School of Medicine. The schools agreed to use the building which had belonged to the former Medical College of Indianapolis.<sup>26</sup>

There were many problems encountered by the new conglomerate medical school. The pruning of the faculty was a most painful process. Furthermore, a lack of facilities was a severely limiting condition which apparently plagued all new medical schools. Year after year the request was made for a new building. Then, while the agitation for a new building was at its height, the old building caught fire—not once but twice. Could it be that these medical adventurers were as unscrupulous in obtaining buildings as they had been in obtaining bodies? In 1919 a new medical building was completed at a cost of \$238,000. A wing was added to this structure in 1927. The building is still in use.<sup>27</sup>

Philanthropists traditionally have been helpful to medicine and medical education, and philanthropic citizens of Indiana have played an important role in financing construction of hospitals at the medical center. On March 26, 1911, the Indiana legislature accepted a gift of \$200,000 from Dr. Robert W. Long with the stipulation that this gift was to be used for construction of a hospital on grounds provided by the state. Dr. Long eventually increased his gift to \$260,000. A site was purchased from Joseph Wright, construction was started in 1912 and the new hospital was dedicated on June 12, 1914. The clinical building was added in 1936. The lo-





THE Robert W. Long Hospital as it looks today. The gift of the late Dr. and Mrs. Robert W. Long, this hospital was the first building on the present Medical Center site, having been completed in 1914. In 1949 an additional floor was added by enclosing the sundeck.

cation of the hospital caused considerable debate and turned out to be much more important than was realized at the time, since the decision determined, in a general way, the location of all other buildings at the medical center. The original plan was to build the hospital on one of three plots which belonged to the state. The city, however, was violently opposed to the use of any of the three plots for hospital purposes. When the impasse appeared beyond resolution, Governor Thomas Marshall recommended that the Legislature approve \$50,000 to buy new land for the location of the hospital and such other buildings as might later be added. The new 17.5 acre plot was purchased for approximately \$37,000. Substantial land additions to the original acreage have been made since then.<sup>28</sup> The site proved very satisfactory, and it is difficult to imagine the large complex which now exists in any of the three places first considered.

On the night after the burial of Indiana's beloved James Whitcomb Riley, "The Hoosier Poet," a group of men met in the office of William C. Bobbs of the Bobbs-Merrill Company (publishers of Riley poems) to plan a memorial. After lengthy discussion, Dr. LaFayette

Page, a physician much interested in children, pointed out that crippled children could not play in a proposed playground. There was just one perfect memorial for such a man—a great hospital for children, The James Whitcomb Riley Hospital for Children. It is believed that approval of the suggestion was aided by a recitation of Riley's poem entitled "The Happy Little Cripple,"<sup>29</sup> which tells of a nine-year-old boy with "curv'ture of the spine."

Dr. T. B. Rice wrote a vivid description of the overwhelming approval of the plan:

"Eureka! The idea took with

a flash which stirred Hoosierdom as has nothing before or since. School children were asked to give their mites, and rich and poor gave what they could; clubs and organizations of all sorts wanted to help with appropriate recognition and without appropriate recognition. Every contributor had his name inscribed in the Golden Book—children who gave a penny have their names in the same size script as was used for those who gave sums in six figures. . . ."<sup>30</sup>

The cornerstone was laid on Riley's birthday, October 7, 1922, and the first patient admitted on November 19, 1924. The contributions continued to pour in and, by 1947, had reached a figure in excess of \$5 million.<sup>31</sup>

Considerable attention has been given to the physical growth of the gigantic I. U. medical complex from its nebulous origins, as this growth provides an excellent example of the rapid advances of medical science in the twentieth century. The expansion likewise demonstrates the development of medicine in the environment of the university. As the university has grown, its responsibilities have also been increased. It



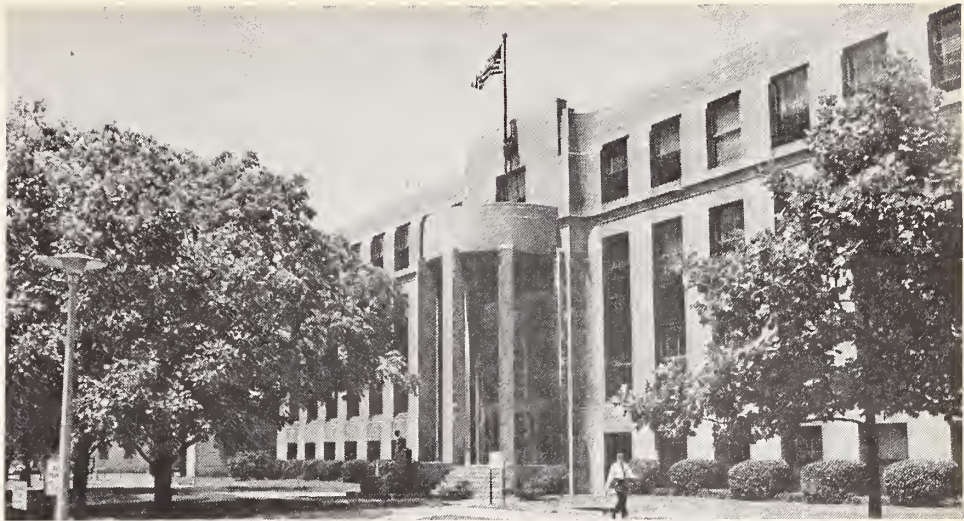
THIS view of the front entrance of the James Whitcomb Riley Hospital for Children gives no idea of the tremendous size of the hospital. In 1971 an \$8.3 million addition incorporating some of the nation's most innovative advances in pediatric care was dedicated. Riley and the other university hospitals are used for the clinical education of more than 3,000 students in medicine, nursing and the allied health professions.



is called upon to provide certain services, other than just the training of physicians, which are important medical needs of society. The Nursing and Dental Schools and the State Board of Health will be considered as examples.

A dental college was established in Indianapolis in 1879. This was the ninth such college in the United States. The Indiana College was organized as a proprietary school and continued as such until it was taken in as part of Indiana University on July 1, 1925. In 1933 the dental school erected a new building adjacent to the medical school.<sup>32</sup> As the similarities between all health fields have been recognized, the two groups of students are now given part of their instruction in the basic sciences in the same building.

The acquisition in 1914 of a hospital of its very own had imposed a new responsibility upon Indiana University. As soon as it was certain that Long Hospital would be built, the trustees and administrative officers of the university had begun to plan for the training of nurses, since this activity is so evidently complementary to the education of physicians and the operation of a hospital. There were seven in the first entering class. Of the seven, five finished their training in June 1917 as the first graduating class.<sup>33</sup> Housing was poor and complica-



FESLER HALL houses many of the administrative offices of the School of Medicine at Indianapolis. It was formerly the State Board of Health Building.

tions many, but the School of Nursing survived and has continued to grow with the institution.

The Indiana State Board of Health actually came into existence March 12, 1896, when Dr. John N. Hurty was elected to the position of secretary of the Board. It was originally housed in the Statehouse and there was a great lack of space. In 1933, when Paul V. McNutt was governor of Indiana, it was decided that the laboratories of the Division of Public Health (the name had been changed) and of Indiana University hospitals should be combined in the interest of economy. The University was by no means enthusiastic about the proposed arrangement, but there was no way

out, as the governor had assumed near-dictatorial powers. The relationship between the University and the Division of Public Health improved, but not without some difficulties. The state finally decided that the Division of Public Health should have a new building and that the building should be erected in the center of the medical school campus. The Division desired the move to the campus to free itself from some political pressures, and the school feared the move because it might bring politics to the campus.<sup>34</sup> Actually, some of both probably happened and perhaps the University has benefited by a closer contact with political realities in solving problems—medical or otherwise. In any event, the building was finished and first occupied in 1939. This building was soon outgrown and turned over to the University when the new State Board of Health Building west of the campus was occupied in 1949.



NOW known as Emerson Hall, this building once housed the entire Indiana University School of Medicine at Indianapolis.

The progress of medical education tends to be measurable not only by dates, men, and social, scientific and political eras, but also by the discoveries and observations of medical educators and research people. The importance of a great discovery, however, is sometimes overlooked in its first light only to



be recognized as a milestone later. One illustration of this public and professional failure to recognize an important event occurred on October 23, 1900, when Walter Reed presented his first paper on the transmission of yellow fever before a session of the American Public Health Association in Indianapolis. The distinguished audience missed the significance of his paper, and little or no comment concerning it was made in the news media of the day.<sup>35</sup>

An institution such as the medical center needs many sources of income. There are always differences which must be filled in between the legislative appropriations and needs that arise. Anonymous donors, the Lilly Foundation, the Indianapolis Foundation, the Indiana Medical Education Foundation and scores of other organizations helped in ways which cannot be accurately evaluated.<sup>36</sup>

In 1951, the Indiana Medical Education Foundation was established. The Foundation accepts all funds coming from the American Medical Education Foundation. The organization was founded with the purpose of providing medical students with a special way to help meet the rising costs of medical education. It serves as a central point for the collection and allocation of funds.<sup>37</sup>

Federal assistance to medical schools has been increasing over the past two decades. During that time, a variety of bills has been introduced in Congress which have been aimed at aiding medical schools and medical education. The bills have differed widely with regard to scope and methods of aid. Among them have been proposals for the establishment of a Federal medical school, for aid to medical schools as well as schools of the other principal health professions, for operational subsidies, for aid in the construction of facilities, for scholarship aid to students, for teaching and re-

search facilities, and for the creation of commissions to study the question of appropriate aid to medical schools.<sup>38</sup> Some of the bills have passed and some are still under consideration. However, federal assistance to medical schools is a very real fact. By 1970, more than \$235 million of federal funds had been spent for medical school construction alone.<sup>39</sup>

Today, the Indiana Medical Center campus occupies some 85 acres approximately one mile from the center of Indianapolis. Instruction in the premedical years is concentrated in the new \$7 million Medical Science Building. The building not only offers every modern facility for medical education, it also contains facilities for research and public service. The school provides training opportunities through its University hospitals (Robert W. Long, William H. Coleman and James Whitcomb Riley) and through the adjacent Marion County Hospital, the Veterans Hospital and the Larue D. Carter Memorial Hospital with a total of more than 2,000 beds. The new University Hospital, at full capacity, provides an additional 700 beds plus the most modern facilities available to medicine.<sup>40</sup>

### **Cyclical Tendency Evident**

As is true in so many historical developments, a "cyclical" tendency is now evident in the growth of the medical education system in Indiana. This paper has previously noted that many medical schools were established in the eighteen hundreds and that those were consolidated into one central institution at the turn of the century. In recent years, "branches" of the medical school have been established in cities throughout Indiana where divisions of the University are located.

This "cycle" is in part due to the fact that the nation has been facing a serious and growing shortage of manpower in the health sciences.

There are many factors which have played a role in the development of the shortage: "a rapid growth in the population; a populace increasingly well educated and thus increasingly aware of the benefits of good medical care; a population of growing affluence with ability to demand and pay for good medical attention; the rapid growth of third-party payment plans, both public and private, which have extended health benefits to larger segments of the population; and the remarkable expansion of biomedical research programs, which have been financed by the public by one means or another."<sup>41</sup>

The term "medical school" and "ideal size" have perhaps restricted thinking when new approaches have been most needed. The term "medical school" has often been used only in reference to a program leading to an M.D. degree. This is fine if the term is reserved for this use, but it must be remembered, and this has been learned slowly, that individuals other than those with M.D. degrees play an important role in rendering health care. Today's "medical center" must be a center for education in the health sciences and for planning in the broadest possible terms for all of the various health professions and vocations.

Similarly, the term "ideal size" has restricted thinking with respect to numbers. All too often, it has been assumed that 100 students in an M.D. program constitute an upper limit beyond which dire but vaguely described consequences would ensue.<sup>42</sup>

To meet the new challenges, the I.U. School of Medicine has embarked on a planned program of growth. It has increased its freshman enrollment from 221 in 1967 to 223 in the fall of 1971. Plans called for 296 freshmen in 1972 and 320 in 1973. This will give I.U. an even larger lead as the largest medical school in the United States.



This has been accomplished by taking advantage of the many teaching facilities throughout the state. In 1971 there were 12 I.U. freshmen medical students enrolled at Ball State University, 10 at the University of Notre Dame, 8 at Indiana State at Terre Haute, and 33 at I.U. in Bloomington, in addition to 200 at the Medical Center in Indianapolis. In 1972, freshman medical students were scheduled to be enrolled in the University of Evansville and the Gary I.S.U. Campus.<sup>43</sup>

At Indiana, basic sciences are taught during the first year and the first semester of the second year. Then the student begins Introduction to Clinical Medicine. The third year is clinical clerkships, with students working on the wards of the teaching hospitals. The fourth year is a totally elective program, with more than 300 clinical and basic science courses available to seniors. This fourth year gives the student a chance to find his area of specialization if he doesn't already know. This placement of additional education upon the prospective doctor should better enable him to relate his training more closely to the needs of the community and the nation.<sup>44</sup>

Additionally, under the Indiana Statewide Medical Education System, many fourth-year clinical electives have been established in community hospitals all across Indiana. In 1971 all but 13 seniors of the 1972 graduating class of 214 were taking some or all of their clinical electives in 51 different hospitals. This not only further eases the strain on the Indianapolis facilities, it also helps the community hospitals develop into the teaching and research centers which they all must be.<sup>45</sup> This same statewide system, through a series of guest lectures, computerized access to the medical school library, (and, if necessary, to the National Library of Medicine) and a closed circuit television network

of 51 hospitals, plans to develop numerous medical centers in the state and encourage practice outside the metropolitan areas.<sup>46</sup>

During recent years, trends in enrollment at the Indiana University Medical School have been similar to the general trends in the country. Enrollment has continued to increase but has not been able to keep pace with increased applications. Applications for entrance into the 1971-72 freshman class jumped 32% to 1,674; admissions inched up 9.0%.<sup>47</sup> The number of graduates from the nation's medical schools increased to 8,974 in 1971, which was 607 more than in the previous year. Total enrollment was also up 2,818 from 40,487. Both of these figures were records.

#### **More Medical Schools Planned**

There are presently 108 schools training physicians in the United States. Five more were scheduled to open in 1972 and at least 120 are expected by 1980.<sup>48</sup> Indiana's program of growth is to be commended but, as these figures indicate, this is the type of expansion which is necessary if the medical school is to meet the demands placed upon it.

A reflection of the increased national interest in providing medical education opportunities for minority students is evidenced by recent enrollment figures. Excluding Howard and Meharry (the traditionally black medical schools) only 0.9% of the students enrolled two years ago were black. In 1971 the figure was 2.6%.<sup>49</sup>

Minority student enrollments at the Indiana University School of Medicine have increased substantially this year. Eleven black students, four of them women, enrolled in the 1971-72 freshman class. There were five black students, all men, in the 1970-71 class. There were 39 women in the 1971 freshman class at the nation's large

est medical school. In 1970 there were 28. An Office of Minority Students has been established in the medical school to recruit and counsel students and to raise funds for loans and scholarships for minority students.<sup>50</sup>

Current evidence indicates that the Indiana Medical Center will continue its rapid growth. A \$1.6 billion cancer fighting bill, just passed by Congress, apparently paves the way for a \$20 million cancer research center in Indiana.<sup>51</sup> A team of national experts in medical diagnostic and artificial heart research is planning to work at Indiana University.<sup>52</sup> These developments should be of great benefit to medical education in the state.

This paper has shown conclusively that medical education is changing rapidly. It is imperative that these changes represent advances rather than retreats. To insure a direction of advancement, it is essential that certain goals be established. An explicit and implicit examination of the goals currently advocated or being implemented indicates that these goals are often highly diverse or even divergent.

These goals should demonstrate the possibilities of medical education becoming highly differentiated. It is true that there are many careers in the health services other than those of the M.D. However, the M.D. degree must never lose its distinguishing mark of excellence. The studies examined in this paper reveal that comprehensive health programs for everyone are developing; scientific and cultural education for the medical student is broadening; and medical schools are adopting programs with broader principles of preventive and social medicine. The coordination and unification of all these factors in the whole educational process will produce doctors fully capable of as-



suming leadership in solving problems of individual and community health.

In setting new goals to meet the demands placed upon today's physician, it is possible that systems of instruction are again to be recast. These new goals must not be established in any manner which might reduce the quality of medical education and practice. The most important question now confronting American medical education asks: "What are these goals and who should set them?"<sup>53</sup>

### Acknowledgement

Members of the Indiana University staff were very helpful to me in preparing this paper. They gave me full access to the University library facilities at both Indianapolis and Bloomington and suggested references which proved to be most useful.

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## About Our Cover

Indiana University School of Medicine occupied this building, which stood at the northwest corner of Senate and Market streets in Indianapolis, from 1908 to 1919. The building was constructed in 1895 by the Medical College of Indiana through the generosity of a Marion surgeon, Dr. William Lomax.

The Medical College of Indiana, the Central College of Physicians and Surgeons (both of Indianapolis), and the Fort Wayne Medical College combined their facilities to form the Indiana University School of Medicine.

This building was later occupied by the Indiana State Board of Health and by the Indiana State Highway Commission. It was razed a few years ago to make way for the Indiana State Office Building. C.A.B.



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are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

**Precautions:** Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with anti-hypertensive agents may result in an additive hypotensive effect.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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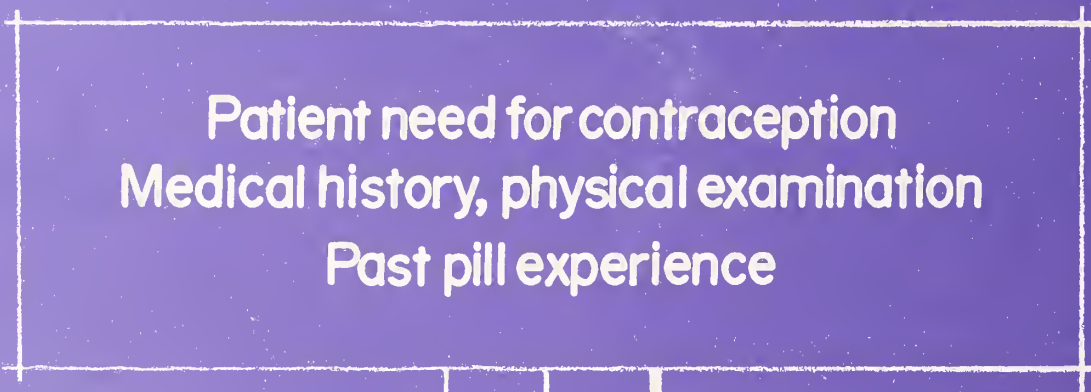
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**Actions**—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

**Special note**—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

**Indication**—Ovulen and Demulen are indicated for oral contraception.

**Contraindications**—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

**Warnings**—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain<sup>1-3</sup> leading to this conclusion, and one<sup>4</sup> in the United States. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll<sup>3</sup> was about sevenfold, while Sartwell and associates<sup>4</sup> in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as non-users. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

**Precautions**—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of

fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

**Adverse reactions observed in patients receiving oral contraceptives**—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T<sub>3</sub> uptake values; metyrapone test and pregnanediol determination.

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**Indication**—Enovid-E is indicated for oral contraception.

The **Special Note, Contraindications, Warnings, Precautions and Adverse Reactions** listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

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# Recommendations<sup>†</sup> on Combination Live Virus Vaccines

## American Academy of Pediatrics

### Committee on Infectious Diseases

In the September 15, 1971 *AAP Newsletter* sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

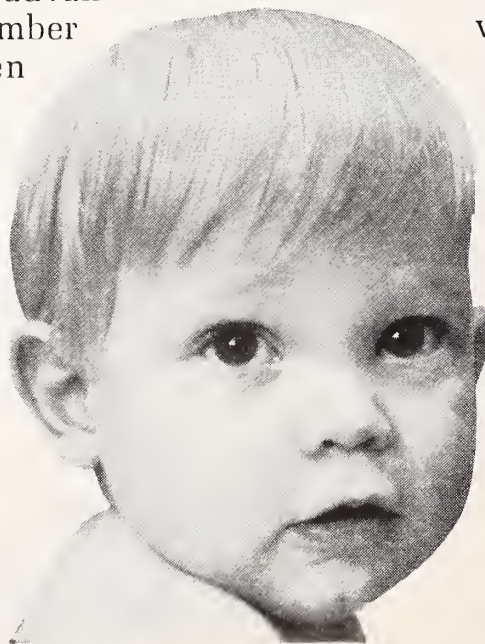
<sup>†</sup>For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.

## United States Public Health Service

### Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidity and Mortality Weekly Report*, the Advisory Committee on Immunization Practices of the United States Public Health Service presented recommendations on the use of combination live virus vaccines. The committee stated that:

- "Data indicate that antibody response to each component of these combination vaccines is comparable with antibody response to the individual vaccines given separately."
- "There is no evidence that adverse reactions to the combined products occur more frequently or are more severe than known reactions to the individual vaccines (see pertinent ACIP recommendations)."
- "The obvious convenience of giving already selected antigens in combined form should encourage consideration of using these products when appropriate."





# M-M-R<sup>\*</sup>

## (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials

M-M-R, given in a single injection, fits easily into your routine immunization program for well babies. Given at age 12 months, M-M-R provides for vaccination early in life against measles, mumps, and rubella.

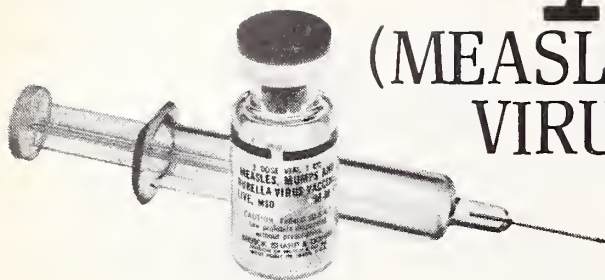
MSD suggested immunization schedule for well babies	
Age	Vaccine(s)
2 months	DPT (diphtheria-pertussis-tetanus) Oral poliomyelitis vaccine (triple)
3 months	DPT <sup>1</sup>
4 months	DPT Oral poliomyelitis vaccine (triple)
6 months	Oral poliomyelitis vaccine (triple)
12 MONTHS	M-M-R (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE, MSD)

1. This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.  
Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

<sup>\*</sup>Trademark of Merck & Co., Inc.

For a brief summary of prescribing information, please see following page.





# M-M-R

## (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

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No untoward reactions peculiar to the combination vaccine (M-M-R) have been reported.

Moderate fever (101-102.9 F) occurs occasionally. High fever (over 103 F) occurs less commonly. On rare occasions, children who develop fever may exhibit febrile convulsions. Rash (usually minimal and without generalized distribution) may occur infrequently.

Since clinical experience with measles, mumps, and rubella virus vaccines given individually indicates that very rarely encephalitis and other nervous system reactions have occurred, such reactions may also occur with M-M-R. A cause and effect relationship, however,

has not been established.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Must not be given to women who are pregnant or who might become pregnant within three months following vaccination.

**Contraindications:** Pregnancy or possibility of pregnancy within three months following vaccination; infants less than one year old; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; therapy with ACTH, corticosteroids, irradiation, alkylating agents, or antimetabolites; blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems; gamma globulin deficiency, i.e., agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia.

**Precautions:** Administer subcutaneously; do not give intravenously. Epinephrine should be available for immediate use should an anaphylactoid reaction occur. Should not be given less than one month before or after immunization with other live virus vaccines; vaccination should be deferred for at least six weeks following blood transfusions or administration of more than 0.02 cc immune serum globulin (human) per pound of body weight, or human plasma.

Due caution should be employed in children with a history of febrile convulsions, cerebral injury, or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur after vaccination.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Attenuated live virus measles and mumps vaccines, given separately, may temporarily depress tuberculin skin sensitivity; therefore, if a tuberculin test is to be done, it should be scheduled before vaccination, to avoid the possibility of a false negative response.

Before reconstitution, refrigerate vaccine at 2-8 C (35.6-46.4 F) and protect from light. Use only diluent supplied to reconstitute vaccine. If not used immediately, return reconstituted vaccine to refrigerator at 2-8 C (35.6-46.4 F), and discard after eight hours.

**Adverse Reactions:** Fever, rash; mild local reactions such as erythema, induration, tenderness, regional lymphadenopathy; parotitis; thrombocytopenia and purpura; allergic reactions such as urticaria; arthritis, arthralgia, and polyneuritis.

Occasionally, moderate fever (101-102.9 F); less commonly, high fever (above 103 F); rarely, febrile convulsions.

Encephalitis and other nervous system reactions that have occurred very rarely with the individual vaccines may also occur with the combined vaccine.

Transient arthritis, arthralgia, and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. Such reactions have been reported with live attenuated rubella virus vaccines. Symptoms relating to joints (pain, swelling, stiffness, etc.) and to peripheral nerves (pain, numbness, tingling, etc.) occurring within approximately two months after immunization should be considered as possibly vaccine related. Symptoms have generally been mild and of no more than three days' duration. The incidence in prepubertal children would appear to be less than 1% for reactions that would interfere with normal activity or necessitate medical attention.

**How Supplied:** Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 TCID<sub>50</sub> (tissue culture infectious doses) of measles virus vaccine, live, attenuated, 5,000 TCID<sub>50</sub> of mumps virus vaccine, live, and 1,000 TCID<sub>50</sub> of rubella virus vaccine, live, expressed in terms of the assigned titer of the NIH Reference Measles, Mumps, and Rubella Viruses, and approximately 25 mcg neomycin, with a disposable syringe containing diluent and fitted with a 25-gauge, 5/8" needle. Also in boxes of 10 single-dose vials nested in a pop-out tray with a separate box of 10 diluent-containing syringes.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486

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Editor: Frank B. Ramsey, M.D., 3266 N. Meridian Street,  
Room 705, Indianapolis 46208.

Associate Editors: A. W. Cavins, M.D., 75 Allendale Place,  
Terre Haute; Lall G. Montgomery, M.D., Ball Me-  
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Medical Center Bldg., Fort Wayne; I. W. Wilkens,  
M.D., 4820 E. Pleasant Run Pkwy, N. Dr., Indianop-  
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## The New Vitamin-Mineral Regulations

THE Food and Drug Administration originally proposed vitamin regulations over 10 years ago. The then preliminary regulations have been the subject of prolonged hearings which lasted over two years.

The final regulations were published recently. They relate to the identity, labeling, formulation and promotion of vitamin-mineral preparations.

FDA Commissioner Alexander M. Schmidt characterized the new regulatory program as follows: "The single most important purpose and effect of the regulations is to require full and honest labeling and fair promotion of vitamin and mineral products, whether marketed as foods, dietary supplements, or as drugs. The regulations redefine and clarify FDA's intentions to act against false labeling or deceptive promotion of such products."

The new regulations establish the U.S. recommended daily allowance (RDA) as the official measurement of nutritional intake. The RDA for the various vitamins and minerals will be specified in four age categories—infants, children

under four, adults and children over four.

Vitamins as drugs and food products containing vitamins will be distinguished by their vitamin content expressed as a fraction of the RDA. A food product containing less than 50% of the RDA is a food and subject to nutritional labeling requirements. Products containing 50 to 150% of the RDA are considered dietary supplements and must be labeled and marketed as such. With the exception of vitamins A and D, a vitamin-mineral preparation containing over 150% of the RDA must be labeled as sold as a drug.

For the present, at least, the FDA will consider vitamins and minerals other than A and D now sold over the counter as acceptable in the non-prescription category.

Vitamin A in dosage above 10,000 international units and vitamin D in dosage above 400 international units will be limited to prescription sale. This regulation may be altered later depending on the findings of the panel which is considering over-the-counter vitamin-mineral sales.

Since the new regulations were announced in January of this year there have been a large number of protests from consumers. Dr.

Schmidt thinks these are based on honest fears but are not well informed. He states: "The new regulations will not alter or interfere with the consumer's basic responsibility for deciding his own nutritional practices. The rules will insure more and better information to guide the consumer in making such decisions."

## Health Education Needed

Dr. Robert Ray McGee of Clarksdale, Mississippi, writing in "Physician's Management" under the pen name of Jonathan Swift, had some interesting things to say in the August issue in regard to the high cost of medical care. Dr. McGee's thesis is that the high cost is mainly due to the modern propensity for "saving lives." Many times this is done heroically, in spite of very poor odds. Dr. McGee thinks one remedy for the high cost would be for doctors to relieve suffering and forget life saving. He says: "The fact is that most people show a singular disinterest in a lot of low-cost, life-saving techniques readily available. There are ways, preventive ways, that would pre-



serve more lives than all our conventional doctoring."

Further: "A majority of our population is busily killing itself with immoderation in the consumption of booze and tobacco, in over-eating, and in physical sloth. The impoverished minorities are sickening and dying less from the lack of specific disease treatment than from their unhygienic environment. A smaller group is Hell-bent on self-destruction with narcotics and psychedelics."

He is right. We do not need more methods of preventing trouble. We need a method which will influence people to take advantage of those common sense measures we already have available.

## The Priceless Advantage

THE Diabetes Detection Drive is scheduled for next month, November 11 to 17.

Everyone—doctors, other members of the health profession, and, in fact, everyone else—is urged to cooperate with and participate in the endeavor to locate the unknown diabetic.

Each year the list of advantages for the diabetic person to achieve by reason of diagnosis and active treatment becomes longer and more important. This year the American Diabetes Association adds the realistic expectation of a real cure for the disease within the next few years.

Even without this brilliant possibility there remains the priceless advantage of early treatment for the diabetic who is not aware of the disease and who has it in the early stages or in the uncomplicated state. Diabetics who are nonsymptomatic or practically so have the greatest opportunity of maintaining good health by good active treatment.

These are the ones most likely to be discovered by routine campaigns and mass screening programs.

The diabetic patient who is diagnosed as a result of an advanced symptomatic stage of the disease has already passed the time when treatment is most effective in prolonging life and comfort.

Physicians should be searching for diabetics every day, all day long, but the mass screening survey conducted annually is also important since it should detect the early and mild nonsymptomatic cases.

## Good Health and Medical Care

THERE are many misconceptions held by nonmedical laymen in regard to the importance and efficacy of preventive medicine and the relation of good health and good medical service.

However, the attractiveness of the issue of good health maintenance is so large in the popular mind and in the view of politicians that the latest vehicle for the provision of medical care is styled "Health Maintenance Organization," despite the fact that there is practically no relationship at all between good health and medical care.

Donald Judd, M.D., president of the St. Louis Medical Society, recently wrote on this subject in *St. Louis Medicine*. His President's Page is quoted below:

"Recently, the concept of health maintenance seems to be newly discovered and growing in popularity. The medical profession is criticized for failing to practice this means of preventive care. New health care plans extol their emphasis on health maintenance and are promoted as means of lowering the cost of health care by avoiding expensive, crisis-oriented hospital care.

"There are diseases in which early detection is important to prevent complications and to lessen the severity of the disease. As examples, diabetes, hypertension, and sickle-cell anemia come readily to mind. However, it is a regrettable fact that the great bulk of disease in this country is not preventable by medical science at the present time. With a few exceptions, the etiologies of the two most common causes of illness and death—cancer and arteriosclerosis—are unknown. Here, our emphasis is on early detection rather than prevention. The same thing is true for the vast majority of serious illnesses. They are not preventable no matter how much medical attention is available.

"There are other means of health maintenance. There are conditions known to be associated with morbidity and mortality, such as cigarette smoking, obesity, alcoholism, drug abuse, and venereal disease. Avoidance of these conditions requires the individual to be responsible for his actions, to regulate his behavior, to abstain from certain desires. In the maintenance of good health, the individual has a large influence. A person who pursues poor health habits probably cannot be kept in a state of good health.

"Certainly, every person should have access to quality medical care in sufficient amounts. Just as certainly, access to health care cannot guarantee good health."

Everyone outside the medical profession should become aware that health and medical care are two different entities. Two different entities that are not closely related.

Health is the result of the fortuitous combination of good heritage, a moderate amount of good fortune, and a reasonable attention to the rules of hygiene—it does not depend, in any more than a slight degree, on medical care.



## The Goose that Laid the Golden Egg

ONCE upon a time there was a country that had the best medicine in the world. Physicians and other medical specialists came from all over the world to learn. People in that country were proud of their medicine. The doctors worked hard to care for their patients and to upgrade and improve the level of medicine. They took refresher courses, established areas of specialization and developed examining boards which would insist that specialty qualifications be high. In general, the doctors were a dedicated lot. Some of them made a lot of money; but very few made as much as they would with the same brains and same diligence applied to business or industry.

But some people were dissatisfied. Some thought doctors should be more conveniently located. Some were disappointed that every doctor was not a perfect father figure. Some thought that they should get medical care free. Some were misled by odd-ball statistics into thinking that the infant mortality rate was higher than it really was. And there were some other complaints.

So, despite the pride the country had in its medicine, there were little splinter groups who wanted this or that changed. And a lot of politicians saw an area where they thought that they could improve on medicine by changing the laws of the land. Some promised to get it wholesale. Others promised to get it free. They had the power to write laws and they were easily hypnotized by their own eloquence.

So a scant majority of the politicians in office at that moment in history got busy writing laws without heeding the advice and counsel of doctors. They took the stand that

if the doctors and the field of medicine didn't fit the laws, then the doctors and the field of medicine would have to change. So they wrote Medicare and Medicaid. Unfortunately, these laws didn't turn out exactly as they had predicated. Then, they said that the doctors were responsible for the failures. So they started writing more laws.

In the end, it just didn't work out that the politicians could get it wholesale or free. There was a strong suggestion that their tampering had slowed the rate of improvement of medicine. Splinter groups were still complaining. So the alarmed politicians blamed the doctors more and wrote harsher and harsher laws.

This state of affairs antagonized and discouraged the doctors. They began to look around for ways of beating the system rather than ways of practicing top-notch medicine.

And that, dear children, is how they killed the goose that laid the golden egg.—**W. David Steed, M.D., Oak Park.**—*Illinois Medical Journal*. July 1973. Reprinted with permission.

## Telling How the Newest Drug-Efficacy Gauge Works

BIOAVAILABILITY has become the talk of the profession faster than the word itself has been able to make it into medical and pharmaceutical reference books. With this in mind, Lederle Laboratories—in conjunction with the Rutgers University College of Pharmacy and the New Jersey Pharmaceutical Association—recently sponsored two seminars on the subject, one for pharmacists in the northern part of the state, one for those at the southern end.

Presenting a sort of base on which the audience could build its knowledge, John Colaizzi, Ph.D.,

professor of pharmaceuticals at the University of Pittsburgh's school of pharmacy, warned that extreme caution should be exercised in substituting, and that people in the profession must keep themselves informed concerning bioavailability. Clinicians testing for it, he explained, chart patient blood level curves that show the speed and intensity, as well as the duration, of a drug's therapeutic effectiveness.

The prescriber's decision should, he said, be based on five criteria: the drug; the dose and regimen; the route of administration; the dosage form; the brand. In this connection, Dr. Colaizzi noted that in 1972, 9.7 per cent of all prescriptions were filled with generics, and, thanks in part to consumerism, there's an ever-increasing number of generic drugs entering the marketplace.

But danger may be courted in substituting a generic for a brand-name drug prescribed, and pharmacists shouldn't let themselves be fooled by rates of dissolution, which do not show bioavailability data. Instead, it's the blood level versus the time level (excretion rate) in humans that points the way to bioavailability. It's a three-way analysis of pharmacologic effect, drug concentration in plasma, and drug, or drug metabolite, in the urine. A drug innovator, added Dr. Colaizzi, has to produce all this evidence to get his product on the market, whereas the me-too brands do not.

(Even after granting these facts, however, there's plenty of room for debate. In the May 11, 1973 issue of *The Medical Letter*, for instance, the following conclusion appeared regarding penicillin: "There is no evidence of clinically important differences in the bioavailability of oral generic and brand-name products. The wide disparity in prices of oral penicillins is noteworthy.")

If it all sounds somewhat perplexing, don't worry. Authorities in



the field agree on only one point, that bioavailability is a new aspect of the pharmacist's responsibility. From the book *Hazards of Medication* by Eric W. Martin, Ph.D. (J.B. Lippincott Co.), one-time director of medical communications of Lederle Laboratories, comes the following explanation:

"Testing methods (for physiological availability) are being developed, but the surface of this complex subject has only been scratched. Determinations that appear to be especially important are disintegration and dissolution rates and blood levels. Attempts to correlate *in vivo* with *in vitro* data are still largely in experimental stages.

"*In vitro* disintegration and dissolution rates are not likely to be the same as the corresponding *in vivo* rates. But *in vitro* rates are probably a guide to the relative bioavailability of two chemically equivalent drug products. The best guide, however, appears to be blood level data, including peak concentrations of the drug, the rates at which they are reached, and the lengths of time that minimum effective concentrations are maintained."

For the retail pharmacist, all this can be boiled down to: When you have equivalence questions about a drug, ask the manufacturer for his bioavailability data.—*Drug Topics*, July 16, 1973. Reprinted with permission.

## Editorial Notes . . .

The "New Republic" recently published an article entitled "Rx: Inexpensive Pills with Costly Labels." One of the points was "Medicine is expensive and inflation has been making it more so." Joe Stetler, president of PMA, replied to the falsification by informing "New Republic" that Rx drug prices were 7.7% lower in 1972 than in 1961, while the All Commodities Index of

wholesale prices rose by 25.6%.

The "New Republic" also said "The cost of the brand label often exceeds that of the pills themselves." Mr. Stetler mentions that the average price for all 19 generic preparations of ampicillin, which was one of the "New Republic's" typical items, is \$11.53. Totacillin is made and sold by the manufacturers who discovered ampicillin. Its price is \$11.36.

**Johnson and Johnson, medical supply and equipment manufacturers, report impressive results from the first year of operation of their Departmental Analysis Program.** In 1972, 424 hospitals participated in the program, which is designed to cope with costs, and achieved an overall savings on surgical dressings of 16.3%. Johnson and Johnson specialists make an analysis of each hospital without charge and offer recommendations for the efficient use of supplies and methods of reducing the cost factor.

**The U.S. Government, at a cost of \$30 million, is researching the answers to questions concerning health care.** It would appear that the answers are obvious but for such a small sum Washington wishes to know for sure. Soon we will be able to say for certainty whether: (1) Erasure of all financial barriers causes surge of demand, (2) Deductibles and co-insurance exert a brake on excessive use, and (3) Families alter their patterns of physician-hospital utilization depending upon their type of insurance.

**A VA hospital clinical study of anticoagulants as used in acute heart attacks involved 1000 coronary thrombosis patients in 10 hospitals.** The death rate was the same for those who received anticoagulants as for those who did not. How-

ever, only 10 of those who received anticoagulants developed clots in the lungs, as contrasted to 24 in the group not receiving the drugs.

**The ENCYCLOPEDIA OF ASSOCIATION has just appeared in its eighth edition since 1954.** Its listing includes 17,000 trade, professional, religious, leisure and cultural groups, more than 1200 of them being new entries. Some of the newcomers are "International Flat Earth Research Society," "Wild Horse Organized Assistance," sometimes known as WHOA for short, and the "Thoreau Quiet Desperation Society." The encyclopedia sells for \$45.

**A comprehensive medical center is being built and will be operated under the auspices of organized labor in Martinez, California.** It includes an acute care general hospital, a convalescent hospital, a preschool day care child center, medical offices and an automated multiphasic health testing service laboratory designed by AML International. The aim is to solve the critical manpower shortage, to change crisis-oriented medical care to health maintenance, and to avoid having specialty-oriented medical care. This will be an ideal method of testing the theories involved; the clientele will have their own money invested and should utilize the facilities as economically as possible. It will be interesting to discover whether enough sickness can be prevented to make the overall medical treatment service any cheaper or better.

**NASA research has developed a small radio transmitter, about the size of a vitamin capsule, which can be swallowed and in passage through the GI tract will transmit the temperature of the deep body**



structures. The receiver must be fairly close to the patient, but there is a re-transmitter, the size of a cigarette lighter which will rebroadcast the signal for 100 feet or so. The sensor can be modified to transmit data other than temperature, such as acidity, intestinal pressure or specific chemicals.

**The American Pharmaceutical Association when sponsoring, a few years ago, a campaign to do away with ant substitution laws and regulations, made it sound as though the thought was to have the doctor make the diagnosis and let the pharmacist direct the treatment.** In fact, some individuals since then have said practically the same thing. Now the APA propaganda emphasizes that the pharmacist should only have the choice of the source of the drug prescribed, not the choice of the basic drug. And the official line crawfishes a little more when it is emphasized that no pharmacist wishes to dispense a brand name drug counter to the physician's desires—all the prescriber needs to do is add the company name to the brand name to insure getting what he wants.

**Another clinical thermometer enters the market with the claimed advantage that it will record the patient's temperature in less than 30 seconds.** The new device does have the advantage of being moderately priced at \$19.95. It also is easy to read and comes with disposable probe covers. However, since the mouth does not achieve the general body temperature until the mouth has been shut for three minutes, there is no advantage connected with the new instrument's fast recording. In fact, the sale of such an instrument with its fancied claim to registering the body temperature within 30 seconds will lead to a lot of fever charts which are misleading and useless.

**Severely handicapped or almost totally paralyzed patients will soon be able to perform simple tasks for themselves through the use of electro-mechanical devices developed by NASA for use by astronauts.** A hospital has been equipped with gadgets which enable the patient to dial and answer telephones, turn the pages of books, open and close curtains, activate and tune radios, television

sets and intercoms, and turn a variety of appliances on or off.

**The Department of Health Education and Welfare has discovered that a visit to a private physician carries an average cost of \$7.82, and that a visit to a neighborhood health center costs \$21.16.** There are only two things that are known for sure about socialized medicine; one is that its quality is low and second its price is high.

**FDA is delaying its decision on proposed restrictions on prescription type cough/cold products.** The cough/cold products sold over-the-counter without prescription almost always contain the same ingredients in smaller doses. FDA has a much longer time table for OTC medications and now is anxious to wait until the OTC panel has ruled on cough/cold remedies in order that the Rx ruling is in conformity. Previous to the delay it appeared that it might become illegal to prescribe a medication that could be legally bought over-the-counter.

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# A Matter of Survival

JOHN G. SUELZER, M.D.  
Indianapolis

LADIES and Gentlemen, may we first thank you for taking time out of your regularly scheduled activities to attend this Governor's Conference on Emergency Medical Services. And second, may we all begin this Conference with a silent prayer that we may pool our knowledge and interests and evolve a plan of action today that will move the state of Indiana down the path to better emergency care for all its citizens. We are, after all, involved in a matter of survival.

Many of us are here today with mixed emotions. The term "mixed emotions" has oftentimes been described as the feeling a man might have upon seeing his mother-in-law drive over a cliff in his brand new Cadillac. Most of you are here today because you are convinced we must do something to improve the chances of survival of the accident victim, the heart attack case and the person with a sudden severe illness. Some may be here because of a certain reservation on how this should be done. Some are here because they fear government regulation and supervision in any form. I think it is safe to say that there are as many mixed emotions bottled up in this audience as there are people and agencies represented. It is our hope that we can release these emotions in a constructive manner.

May I review for you briefly, the events leading up to today?

In 1966 the Federal Highway

Safety Act mandated that state governments plan and implement highway safeguards to lower the skyrocketing toll of traffic deaths. One portion of this act required development of a coordinated and comprehensive statewide emergency medical care system. In Indiana, as in most states, the Governor placed this responsibility with the State Board of Health. An Advisory Council on Emergency Medical Services was formed and, after many months of tedious labor, they produced the Indiana Emergency Medical Services Plan, a plan which was recognized all over the United States for its thoroughness and depth. I think you should know that while many of our sister states hired planning agencies at the cost of hundreds of thousands of dollars to develop their plans, the Indiana Plan was drafted with volunteer workers. Funeral directors, hospital administrators, public health officials, volunteer firemen, physicians, sheriffs, nurses, police and fire chiefs, and many, many others.

This plan has been put in the legislative washing machine three times. The first two times it apparently got shredded. The last time, despite its close association with a lot of low-phosphate detergents, it came out with a ring around the collar. And this last time around the original plan, involving a total concept of ambulances, hospitals, training, communications, records and the like, pretty well shrank down to just ambulance vehicle and attendant training requirements; admittedly very important, but only a part of a total system.

Because of concern over lack of progress and the apparent loss of the original concept of an EMS System, a group of health professionals—nurses, doctors and hospital administrators—met this spring and decided to ask Governor Bowen to call this Conference. And so, here we are.

Why are we here? We are here to provide Governor Bowen and our elected representatives with information to assist them in preparing legislation that would create a statewide emergency health system.

Why are there so many people here? The latest count on attendance at this Conference is 675. This group is this large because those of us who were involved in the planning of this Conference are convinced that the basic concepts and goals of EMS System in Indiana are acceptable to practically everyone and that the problems we have had are related to lack of communication, misunderstanding, a feeling of being left out of the planning, a fear of government domination without representation, and other bugaboos that arise to jinx human-to-human relationships. We have tried to involve everyone who could help or who could learn from this Conference or who might have something to say on the subject, except perhaps Ralph Nader and Martha Mitchell! Also, in many areas of this state the problems will be different. We must have a state plan that can serve a rural county with one hospital through perhaps the local funeral director or volunteer fire department, a medium sized city perhaps through a private am-

Address of the chairman of the Governor's Conference on Emergency Medical Services at Indianapolis on July 23, 1973.



bulance company, and a large city through a municipal system involving several hospitals. A glance at our registration list reveals that all areas of the state of Indiana are represented and that we have collected in one place a tremendous amount of expertise on the subject. This is the reason for the crowd.

I will say a few words about the format of this Conference. Because we have so much to accomplish and so little time in which to accomplish it, it is extremely important that we use every minute effectively. The morning and early afternoon sessions will be occupied by brief talks about the five basic areas of concern in an emergency medical service system. Each speaker will establish what has been done in planning in Indiana and, where applicable, what has been accomplished in other areas of the United States. He will also bring up what still needs to be done and perhaps where our present hang-ups are. There will be no questions from the floor during these sessions because of time limitation. Save your questions. You will have a chance to ask them during the discussion periods.

For each of the five general discussion topics we have a chairman, a speaker and a recorder. The speaker you will hear during the first part of the program and the other two people you will meet during the discussion sessions. These three people have been chosen because of their knowledge of their particular subject and they will be the spark plugs to ignite the study groups this afternoon. They have

been asked to keep the discussion moving briskly and we suggest that filibusters not be allowed. Also, we ask that if you are a member of an organization represented here by several people you break your group up so you may be involved in as many of these discussion groups as possible.

From each afternoon study group we hope to accomplish at least four things. First of all, we want an opinion from that group on reasonable standards and a reasonable program to follow for that part of the total system. Second, we want a reasonable deadline date for implementation of such programs or standards. Remember that it is no sin to start slowly. For example, in standards covering ambulance vehicle and equipment it might be reasonable to suggest an implementation date for standards governing ambulance equipment a year from now. Standards governing the vehicle itself, which necessarily involve more money, might come later. Likewise, there could be one implementation date covering current vehicles and another covering newly purchased emergency vehicles—sort of a grandfather clause. Third, we need a “ballpark figure” of the cost of that part of the total effort. I’m sure a lot of you in this group may have no idea whatsoever of costs, but we think, from reviewing the registration list, that there are enough people represented here today who do know such things that we can come out with a reasonable figure. Fourth, we need to know the feeling of the

group as to organizations and/or people who should function on a continuing committee supervising that portion of an EMS System.

That sounds like a real hum-dinger of a job, doesn’t it? But I don’t think it will really be as hard as it sounds, because 99% of it has been thought and re-thought in state after state and here in Indiana. Much of it is as acceptable as Motherhood and the Flag. It is the remaining little bit that isn’t that we hope all of you can thrash out today. Please keep in mind also that negative opinions are as vital to this conference as positive ones.

As a finale, the leaders of each discussion group will tabulate the consensus of that group and present it at the wrap-up session this afternoon.

If we can all buckle down to the task, take an active part, argue, make suggestions, gripe, listen and learn, and remember that it is death, accidental injury and sudden illness that is the enemy, not the person sitting in front of us, then we can in one day review the efforts of many Hoosiers who drafted the original Indiana EMS Plan, change it where necessary, make concrete suggestions for implementation and, what’s more important than anything else, go home tonight with the satisfaction that we have helped to launch a plan that can save hundreds and hundreds of lives—perhaps even our own. We are today, after all, involved in a matter of survival. ◀

3266 N. Meridian St.  
Indianapolis 46208

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AMA membership insurance plans will be reviewed and evaluated by a new Committee on Insurance. On the committee are Trustees Donald E. Wood, M.D., Indianapolis, chairman, and Burt L. Davis, M.D.; Delegates Samuel M. Day, M.D., Florida, and Frank W. Jones, M.D., North Carolina; Henry B. Asman, M.D., Louisville, and Garth E. Fort, M.D., Nashville. The AMA insurance program includes group term life and excess major medical plans, and negotiations are proceeding on a group hospital indemnity plan and an accidental death and dismemberment plan.





## A HORSE-AND-BUGGY DOCTOR IN SOUTHERN INDIANA

Elizabeth Zulauf Kelemen, Historic Madison, Inc., 301 W. First, Madison, Ind. 47250; 136 pages; price \$3.95 plus 14¢ postage.

William Davies Hutchings was born September 15, 1825, at Lexington, Ky., and died April 2, 1903, in Madison. As a young doctor, William Hutchings practiced in Wooster, Scott County, Indiana. In 1876 Dr. Hutchings and his family moved to Madison. He at first had his office in his home but later bought a building that became his office and hospital. It was this building that apparently led Mrs. Kelemen, Dr Hutchings' granddaughter, to write this delightful little book.

The office, which contains the original furnishings and equipment, has recently been restored as a museum and is open to the public (write Historic Madison, Inc., or call Madison Chamber of Commerce for hours). The Jefferson-Switzerland County Medical Society contributed funds to aid in its restoration and operation.

This book will be of interest to those who would like to savor something of the life in Southern Indiana in the last half of the nineteenth century. The first part of the book tells something about the Doctor and his family. Much of this has been obtained from old letters and many of these are quoted. Mrs. Matilda Hutchings was a poet and a number of her poems are printed in the middle of the book. Almost one half of the book consists of old photographs of the Hutchings' family and Southern Indiana.

The letters add much to the flavor of the book. These have been written by various members of the family and include several describing the practice of medicine and medical education. Most doctors would enjoy spending a short time with "A Horse-And-Buggy Doctor in Southern Indiana."

ELTON HEATON, M.D.  
Madison

## THE CIBA COLLECTION OF MEDICAL ILLUSTRATIONS: VOL. 6, KIDNEYS, URETERS AND URINARY BLADDER

Frank H. Netter, M.D., with some three dozen collaborators, edited by Robert K. Shapter, M.D., and Fredrick F. Yonkman, M.D., Ciba Pharmaceutical Co., Summit, N.J., 1973; 1 to 5 full color plates per page; 295 pages; \$30.

Having exhausted the superlative encomiums on Vol. 5 (See *JISMA*, March 1970, p. 276), I become all but baffled in trying to do justice to this latest in the series.

Dr. Netter continues with his matchless, meticulous, skillful sketching of the human body. The luminaries providing the text are the most clear, concise teachers extant! It would be all but chutzpah on my part to challenge any of them. Of course,

I failed to discern any errors of any sort!

It continues to be a real thrill to scan the magnificent "sketches" and the accompanying text. From the lowliest frosh to the most distinguished head of a medical school department these volumes can instruct, titillate and all but awe the reader.

Nothing that a mere reviewer can say will alter in any way the naked fact of this set by Netter being THE towering master in the field. The price being charged is a mere trifle for what one gets. Congratulations all around!

ARNOLD LIEBERMAN, M.D.  
New York

## ECHOCARDIOGRAPHY

Harvey Feigenbaum, M.D. and Sonia Chang, B.S., Lea and Febiger, Philadelphia, 1972; 239 pages, liberally illustrated; \$11.00.

Because it is a very new technique, most readers will have little foreknowledge of echocardiography before embarking on Dr. Feigenbaum's book. The writer of this review, who was one of the uninitiated, found the volume most interesting and instructive, but in many ways, hard going. For those more expert in technical matters and gadgetry, it will be less difficult.

To the techniques of electrocardiography, cardiac catheterization, and angiography has been added the recording of ultrasound waves bounced against the various walls and valve leaflets of the heart and reflected back into the transducer from which they originated.

It is a non-invasive and apparently harmless procedure which, properly carried out and properly interpreted, adds significant information to that already gained by the older techniques. In addition to the harmlessness of an echocardiographic examination, Dr. Feigenbaum points out that its cost is about 1/200 that of cardiac catheterization, including the hospitalization required. He also calls attention to the fact that, because the patient is under no undue stress and does not have to be sedated, basal hemodynamic information is recorded. Basal conditions are often impossible with cardiac catheterization and angiography. Beyond that, it is much simpler to repeat the non-invasive technique of echocardiography at frequent intervals to determine the patient's progress than would be practical with these other procedures.

There are, however, limitations to the successful use of the echocardiograph. Since ultra-sound waves propagate very poorly through a gaseous medium such as air, results in patients with emphysema are less valid than in those whose hearts are closer to the anterior chest wall. A large muscle mass over the pericardium is also something of a handicap. Beyond that, there seems to be abundant opportunity for faulty interpretation of the tracings if the placement of the transducer is not extremely accurate.

In the hands of Dr. Feigenbaum, one of the pioneers in the use of this exciting diagnostic tool, it has yielded spectacularly useful facts about the thickness of the pericardium, the ventricular and auricular walls, the size of the heart chambers, and the movements of the valves. One gathers that the information gained of the hemodynamic state of valve leaflets is more complete than that gained by any technic other than direct inspection by the surgeon. For instance, the experts can recognize the presence of a flail posterior or anterior mitral valve leaflet and identify hypertrophic subaortic stenosis with more certainty than is possible with any other method. Also, atrial tumors are more easily identified. As we would expect, pericardial effusions seem to be more accurately identified than is



the case with usual roentgen ray techniques. As might be anticipated also, the differentiation of myocardial ischemic disease and other types of myocardiopathy is much less certain.

Taken altogether, the book of Feigenbaum and Chang is a most stimulating and informative exposition of this new development in cardiac diagnosis. Study of it, without months of concentrated work in the heart study unit, will not make a reliable echocardiographer or even interpreter of the reader. But from it one can get some knowledge of the principles involved and the diagnostic possibilities when it is used by those, like Dr. Feigenbaum, who have mastered the intricacies of echocardiography.

PAUL S. RHOADS  
Richmond

## CHILDHOOD PSYCHOPATHOLOGY

An Anthology of Basic Readings, edited by Saul I. Harrison, M.D., and John F. McDermott, M.D., New York, International Universities Press Inc., 1972; 903 pages; nine parts; \$20.00.

Professor Harrison is an eminent child psychiatrist; Professor McDermott is of the same breed. The nine parts of this weighty compendium are labeled: 1) Development, 2) Developmental Disorders, 3) Neurotic Disorders, 4) Learning Disorders, 5) Antisocial Disorders, 6) Psychophysiological Disorders, 7) Childhood Psychosis, 8) Mental Retardation and 9) Brain Dysfunction. One of the articles in part three has been written by S. A. Szurek, who co-authored with me some research studies at the University of Chicago—too many decades ago.

In this age of increasing specialization, I—an internist—am somewhat intrigued as to the why of my being chosen to review a volume quite remote from my present field of endeavors. Be that as it may, I took great pleasure in scanning this opus: slowly and repetitively. In fact, I think I acquired much new (to me) information, even if a great deal of the material is really elementary, on the college teacher level. And that is really the nubbin of my thoughts. The child psychiatrists and psychologists will find here a veritable mine of information. The ordinary M.D. and the specialists in other branches of Medicine will—maybe—glance through this: more for relaxed reading than anything else.

As always, the binding, printing and paper are excellent. The typos are few and insignificant. The format is splendid. The specialist buying this compendium will certainly be more than getting his money's worth!

ARNOLD LIEBERMAN, M.D.  
New York

## VITAMIN E AND ITS ROLE IN CELLULAR METABOLISM

Symposium by numerous international authorities held in New York City December 1972; editors Padmanabhan P. Nair, Herbert J. Kayden, Biochemistry Section; Annals of the N.Y. Academy of Sciences, vol. 203; 243 pages; paperback; innumerable tables, illustrations and graphs and exhaustive references.

The sober perusal of this unpretentious pamphlet should be required reading for just about anyone who feels impressed by his store of knowledge! For lo these many decades I've known that Vitamin E is one of many so-called trace sub-

Continued

## HELP FOR THE CONGENITALLY HANDICAPPED

**CHILD** It wasn't so long ago that congenitally handicapped children were allowed to reach school age or even later before being fitted with a prosthesis. In recent years, experience has shown that fitting at an earlier age produces more effective results—both mentally as well as physically. HANGER provides individually designed prostheses to give aid to the congenitally handicapped child. Children with "HANGER PROSTHESES" can live normal lives. Using their HANGER appliances they exercise freely, ride bicycles, roller skate, play basketball, tennis, and engage in most of the activities like other growing children. These activities enable the child to become self-reliant. Each HANGER prosthesis follows much the same design as those for the adult, but utilizes specially developed components of appropriate size, thus providing a smoother transition as the child grows into adulthood. HANGER also provides devices and techniques for the initial fitting of infants and problem cases. Training of children in the use of their prosthesis is highly desirable, even though children present some problems not seen in adults. Since the attention span of young children is short, extreme patience is required. Some handicaps make an ideal gait-pattern difficult if not virtually impossible to achieve. It should be noted that complete cooperation of the parent is necessary regardless of the experience and ability of the therapist. (Often the parents pass on a sense of guilt that is completely unfounded as there are no known preventive methods to combat the problem of a congenital handicap.)

*Hanger*  
PROSTHESES

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stances essential to normal biology of the living organism. I've been aware that it is a *Lipid Antioxidant* inhibiting undesired destructive peroxidation of polyunsaturated lipids: this is how it maintains membrane stability in just about all living cells.

However, I was totally unaware of the vital complementary role played by another trace substance: the metal selenium, no less. The topic is so complex, at least to me, that I still do not really understand the mechanism of the maintenance of heme stability by the interplay of these trace substances. Also, my mathematics are simply inadequate to grasp the interrelationship of serum Vitamin E and lipid levels in the formula expressing nutritional adequacy!

Finally, I was astounded to be told that in *CYSTIC FIBROSIS* (of all things) a simple serum test will give the extremely low level prevailing and so furnish an unequivocal diagnosis.\* Never mind all the hitherto complex and not-too-satisfactory maneuvers deemed necessary to establish the diagnosis beyond the shadow of a doubt.

Mayhap that distinguished Nobelist Linus Pauling is right on target when talking about Vitamin C, the *really* minimum dosages required and the medical profession's acceptance of data now being proven wrong!

\*Bennett and Mewanowski, 1967, *J. Clin. Nutr.* 20:415.

ARNOLD LIEBERMAN, M.D.  
New York

## SAY AAAH! A COLLECTION OF ANGIOLOGISTS FAVORITE RECIPES

Mrs. Mark G. Herbst, editor, recipes by wives of angiologists, New York, Westminster Publications, Inc., 1973; 155 pages; several illustrations; price not stated.

It is indeed a treat to receive a recipe book such as this entirely unsolicited, all merely for being a Fellow of the International College of Angiology! There is *NO* charge to members of the College; I imagine that other M.D.'s could get this for the usual price of a reprint.

From Gazpacho to Eastern Shore Stew to Cashew Nut Barfi to Pecan Pie: it is all neatly spelled out for you—be it Brazil, Portugal, India, Peru, Japan, Ireland, Sweden or even Brooklyn, N.Y.

And—on page 3—there is neatly and most imaginatively given the recipe for "HOME HAPPINESS CAKE." Read it and your evening is made! Congratulations to Mrs. Royal Brown of Riverside, California.

There is a first time for everything: even the review of a recipe book in a medical journal! Read it, try it, you may even like it!

ARNOLD LIEBERMAN, M.D.  
New York

## AUSTRALIA ANTIGEN

Edited by James E. Prier and Herman Friedman, Baltimore, University Park Press, 1973; 15 articles by different authors, a symposium held in Philadelphia, Nov. 1971; 236 pages; numerous figures, illustrations and tables; price \$12.50.

It is only now becoming clearly evident that hepatitis may

be caused by ingestion of the virus or (shall we say *and?*) by blood transfusions carrying the contaminating material. The previously sharp distinctions made between the fecal-oral INFECTIOUS virus and the peroral (usually via blood transfusions) longer incubation virus are becoming quite blurred. We seem to be dealing with just about the same entity.

Merely because the specific virus was first isolated from the blood of an Australian aborigine, the antigen has been titled *Australia Antigen*! It should be clearly understood that the disease is endemic on a worldwide scale. This particular symposium deals with the specific problems of identifying the blood of donors-to-be in regard to the presence or absence of the *Australia Antigen*.

The radioimmune assay, fluorescent antibody, complement fixation and hemagglutination: they all vary enormously in sensitivity, complexities of techniques, etc. The Army in its very recent publications (as quoted in "Enzymes in Medicine," Vol. VI, #6, 1973) states that—under the best of conditions—soldiers "averaged around 15% infections after blood transfusions."

In sum, then, this is a strictly interim report on an unfolding problem whose dimensions are much greater than first envisaged. We can only hope that within the next decade or so the problems being raised will be much nearer final answers. Of course, the paper, binding and editing are up to usual standards. For what the reader gets, the price is more than modest.

ARNOLD LIEBERMAN, M.D.  
New York

## THE LOW BLOOD SUGAR COOKBOOK

Margo Blevin and Geri Ginder, First Edition, Doubleday & Company, Inc., 1973; 520 pages not illustrated but with hundreds of recipes and diet food lists; \$8.95.

This is a much needed book—few people know the basic content of foods. To be told to eat a high protein, low carbohydrate, low fat diet means to most patients, to eat lots of meat and no desserts.

The book contains an excellent list of foods to avoid and foods to enjoy. There is a marvelous list of "Brand Name" foods with addresses which should help any "Special Diet" patient, be he diabetic, hypoglycemic or destined for low fat.

The recipes are original and the preparation well described. However, the use of saccharin tablets could be more easily handled if the tablets were to be dissolved in a tablespoon of water before adding to the food. A more uniform flavor will be achieved.

Recipes of special note are those for Mexican, Chinese, Jewish, and other racial groups. Also, the use of cottage cheese to produce sour cream; apples and prunes to make a substitute for raisins; new ideas for breading fish and meat and many others are especially helpful to those who prepare special diets.

I would recommend this book as a "must" to patients and families as a guide on handling and simplifying the hypoglycemic diet.

MILDRED R. RAMSEY  
Indianapolis



Abstracts from Various  
Literature, Prepared by AMA

**PITFALLS OF LOCAL EXCISION IN TREATMENT  
OF CARCINOMA OF BREAST**

J. P. SHAW et al. (Memorial Hosp., for Cancer and Allied  
Diseases, New York 10001)

*Surg. Gynecol. Obstet.* 136:721-725 (May) 1973.

The diagnosis of carcinoma of the breast was established by  
local excision of the palpable lump in 508 patients, following  
which an immediate mastectomy was performed. Residual or  
multicentric cancer was demonstrated in 59% of the mas-  
tectomy specimens. The incidence of multicentric carcinoma as  
well as involvement of the axillary nodes was directly propor-  
tional to the size of the primary lesion. Cancer in the contra-  
lateral breast was demonstrated in 22% of the patients.

**SHOULD AIR HOSTESSES CONTINUE FLIGHT  
DURING FIRST TRIMESTER OF PREGNANCY?**

R. T. CAMERON (Medical Dept., Ciba-Geigy Ltd., Basel,  
Switzerland)

*Aerosp Med* 44:552-556 (May) 1973.

There is no evidence that either flying per se or the hypoxia  
induced at a cabin altitude of 5,000 to 7,000 ft has any dele-  
terious effect on mother, embryo or fetus. Air hostesses should,  
therefore, be permitted to continue flight duty during the first  
trimester of pregnancy. The blood gas values and other physio-  
logical factors do not fluctuate so much as to affect the fetus.

**TEN-YEAR EXPERIENCE OF MODIFIED-FAT DIETS  
ON YOUNGER MEN WITH CORONARY  
HEART DISEASE**

M. L. BIERENBAUM et al. (Atherosclerosis Research  
Group, 48 Plymouth St., Montclair, N.J. 07042)

*Lancet* 1:1404-1407 (June 23) 1973

One hundred men, 30 to 50 years old, with confirmed coro-  
nary artery disease and past myocardial infarction, were placed  
on a 28% fat diet after weight reduction. This group was  
matched with a similar group not under dietary management.  
Over a period of 10 years there were significant reductions in  
serum lipids in the diet-managed group compared with the  
control group. After 10 years, the diet-managed group had a  
17% greater survival rate than the control group.

**HUMAN BUBONIC PLAGUE FROM EXPOSURE  
TO NATURALLY INFECTED WILD CARNIVORE**

J. D. POLAND et al. (Ecological Investigations Program,  
CDC, P.O. Box 551, Fort Collins, CO 80521)

*Am. J. Epidemiol.* 97:332-337 (May) 1973.

In February 1972 a 19-year-old male Flagstaff, Ariz, college  
student developed typical symptoms of bubonic plague. The  
patient had skinned a bobcat two days earlier. *Yersinia pestis*  
subsequently was identified from an aspirate of the patient's  
right epitrochlear lymph node and from the bone marrow and  
brain of the bobcat. The patient recovered without complica-  
tion when given broad-spectrum antibiotic therapy. Two other  
students who assisted in the skinning remained asymptomatic  
as well as seronegative to fraction 1 of *Y. pestis*.

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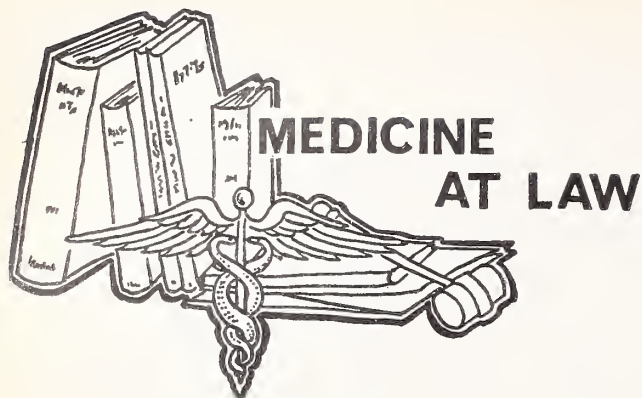
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**Jury Instructed on Contributory Negligence**—A jury instruction on contributory negligence was not reversible error where, although evidence of such negligence was based on hearsay, there was no timely objection to its admission, an Indiana appellate court ruled.

A widow brought action against two physicians, who were partners, to recover damages for the wrongful death of her husband, who was treated by one of the physicians. The husband died of a cerebral hemorrhage. The widow sought to prove that the hemorrhage resulted from a condition that developed over a period of months and that if it had been diagnosed early enough it could have been treated.

The widow testified that her husband had complained of repeated headaches for seven to nine months before his death. She said he had complained of the headaches to the physician, who made a diagnosis of migraine headaches and prescribed medication. She contended that the alleged diagnosis and treatment were negligent.

The physician had been treating the husband for several years for a heart condition. He testified that the husband did not complain of headaches and that he did not make a diagnosis of migraine.

The jury brought in a verdict for the physician. On appeal, the widow contended that the trial court erred

in refusing her motion to strike portions of testimony by witnesses for the physicians and in giving the jury instructions on contributory negligence over her objections.

Four witnesses testified to the effect that shortly before his death the husband had been involved in a barroom altercation. At that time he allegedly received a blow to the head, contributing to the injury causing his death. One of the witnesses was acquainted with the husband and had accompanied him to the bar. The other three did not learn of the husband's identity until later.

The widow contended that the witnesses' testimony should have been stricken from the record because it was based on hearsay evidence as to the identity of the person who was struck on the head. The appellate court conceded that the testimony as to how the witnesses learned the identity of the man in the bar was based on hearsay. It did not agree, however, that the trial court committed reversible error in admitting the testimony. The widow's only objection to the testimony was in the form of a requested jury instruction that no consideration be given to the testimony regarding a blow on the head. Since the widow made no timely objection to the evidence, the court found that the trial court was correct in refusing the instruction.

The widow also contended that

since the testimony as to the man's identity was based on hearsay, it was of no probative value. The appellate court found that the issue as to the probative value of the testimony was with regard to the weight rather than the admissibility of the evidence. Thus, the court said that the trial court had correctly ruled that it was a question of fact for the jury.

The widow further argued that the trial court erred in instructing the jury on contributory negligence when there was no competent evidence on the issue. However, the court pointed to the testimony of the four witnesses, which was properly admitted into evidence. Affirming the judgment of the trial court, the appellate court found that there had been no error in instructing the jury on contributory negligence.—*Norington v. Smith*, 290 N.E.2d 60 (Ind.Ct. of App., Dec. 12, 1972).

**Insurance Benefits Claimed for Pre-Existing Condition**—In an action for recovery of benefits under a health insurance policy, an Indiana appellate court ruled that summary judgment in favor of the insured persons was not proper where a material issue of fact existed as to whether a condition was capable of being diagnosed by a physician before the effective date of the policy.

A family health insurance policy issued on Dec. 15, 1969, provided that payment for a condition existing prior to the effective date would be made only after a lapse of 270 days after the effective date. The policyholders' 4-year-old daughter underwent a routine eye examination on Jan. 13, 1970. At that time it was discovered that she had an eye condition known as bilateral optic atrophy. The physician estimated the time of the medical origin of the disease as between November, 1967, and July 1969. The par-



ents did not know of the condition prior to Jan. 13, however, as there were no previous symptoms.

The child was operated on for the eye condition, and the insurance company denied payment of the medical and surgical bills, amounting to \$892. The company based its refusal on the ground that the disease existed before the effective date of the policy.

The parents filed suit to recover the insurance benefits. The trial court granted summary judgment for the parents, and the insurance company appealed.

The insurance company contended that the disease existed if it was capable of being diagnosed, whether or not it produced symptoms. The parents' position was that the disease existed only when it first became known to them, or on Jan. 13.

The court said there was an issue as to whether the child's eye condition could have been diagnosed by a physician before the effective date of the insurance policy. The child had not complained of any trouble, and she had not had any previous eye diseases or symptoms that would have caused her parents to take her to a physician. The court pointed out that the physician who diagnosed the condition and the surgeon only estimated the date of inception of the disease. There was no question before the trial court as to whether the disease was capable of being diagnosed before the effective date of the policy. Reversing the judgment of the trial court, the appellate court sent the case back for determination of whether a material issue of fact existed as to whether the eye condition was capable of being diagnosed by a physician before the effective date. — *Mutual Hospital Insurance, Inc. v. Klapper*, 288 N.E.2d 279 (Ind.Ct. of App., Oct. 30, 1972).

**Treating Physician may Answer Hypothetical Question** — The answering of a hypothetical question by the treating physician of a party being tried did not violate the physician-patient privilege, an Indiana appellate court ruled.

A man was charged with operating an automobile while under the influence of intoxicating liquor. The automobile he was driving struck a patrol car from the rear. One of the officers administered first aid to prevent shock and stop bleeding. At the time he noticed a strong odor of alcohol. An unopened can of beer was found in the car, attached to a plastic binding used in six packs.

One police officer testified that the driver's speech was slurred, that he was loud and boisterous, and that there was a strong odor of alcohol on his breath. Another officer conducted a breathalyzer test, which showed the man to have a 0.12 per cent level of alcohol. A 0.10 per cent level was considered to indicate intoxication.

The driver's treating physician was called as a witness for the state. He was asked a hypothetical question as to whether in his opinion a person having the odor of alcohol, with slurred speech and various other characteristics, would be under the influence of an intoxicating beverage. The physician answered that such behavior was not normal and that such a person was probably under the influence of some intoxicating drug. When objection was made to the physician's testimony because he was the physician who treated the driver, the court pointed out that the question was hypothetical and had nothing to do with the man personally.

The driver was found guilty, sentenced to the state farm for 30 days, and fined \$100. On appeal, the man contended that his conviction was not supported by sufficient evidence

and that the court erred in permitting a physician to render an expert opinion in response to a hypothetical question based on facts previously placed in evidence.

The appellate court said that the state could ask a hypothetical question of the physician as long as it conformed to the state's theory and was supported by evidence that had already been adduced by reasonable inferences to be drawn from it. The court found that the question was not violative of a privileged communication.

Further, the court said that the man failed to show he had been harmed, since the evidence of intoxication was cumulative and previous testimony had shown that he was intoxicated. Affirming the judgment of the trial court, the appellate court found no error.—*Robertson v. State of Indiana*, 291 N.E. 2d 708 (Ind. Ct. of App., Jan. 24, 1973).

**Malpractice Claim Not Barred by Accident Victim's General Release** —An accident victim's release of the driver of the other car did not bar his claim for malpractice against a physician who treated his injuries, the Indiana Supreme Court ruled.

The accident victim received medical treatment from the physician on the day of the accident. After receiving payment of \$25,621 from the driver of the other car, he subsequently signed a general release in favor of the driver and "any and all other persons" for "any and all known and unknown personal injuries."

The victim brought action for malpractice against the physician for negligence in his care and treatment. The physician filed a motion for summary judgment, which the trial court granted.

On appeal, the court found that the question as to whether the physician was entitled to the benefit of the release was controlled by

Continued



state law. Because there were no clear controlling precedents in the state supreme court decisions, the appellate court certified the question to the supreme court for instructions as to whether the release barred the claim against the physician.

The physician contended that a release to the party responsible for the original injury barred an action against a physician who treated the injury negligently. His point of view was based on the principle of proximate causation—that is, the theory that the original wrongdoer could foresee the aggravation of injuries. Since a general release to the original wrongdoer would include release of liability for aggravation of the injury, it would have to cover any claim against a negligent physician in order to prevent the injured party from double recovery.

The court pointed out that the fear of double recovery was unfounded, since the amount received from the original wrongdoer would have to be credited against amounts received in an action against a sub-

sequent wrongdoer. Further, the subsequent wrongdoer would not be liable for damages other than those caused by his own actions.

The court said that two factors determined the effect of a release: whether the injured party received complete satisfaction and whether the parties intended that the release be in full satisfaction of the claim. The court found that the release in the present case did not bar the accident victim's claim against the physician.—*Wecker v. Kilmer*, 471 F.2d 782 (C.A.7, Nov. 30, 1972); 294 N.E.2d 132 (Ind. Sup. Ct., April 4, 1973).

#### Physician not Liable for State- ments at Commitment Hearing—

A physician who testified at a temporary commitment hearing was not subject to civil liability for his statements at the hearing, an Indiana appellate court ruled.

The patient was temporarily committed to a state psychiatric hospital. The physician testified at the

commitment hearing that the patient was suffering from mental illness and that he should be admitted to the hospital. The court issued the commitment order based on the physician's testimony.

An action was brought by the patient, who charged the physician with negligence in making the report on his mental condition. The trial court granted the physician's motion for summary judgment, and the patient appealed.

The physician acted as a witness in the temporary commitment hearing, said the Indiana appellate court. Therefore, his testimony was privileged and he was not liable for civil damages.

The court further ruled that the physician's testimony was not the cause of the patient's damages. The judge who issued the commitment order actually caused the patient's hospitalization. The trial court's decision was affirmed.—*Rhiver v. Rietman*, 265 N.E.2d 245 (Ind. App. Ct., Dec. 28, 1970). ◀

WHEREAS, surveys indicate approximately 37 percent of the nearly 14 million pre-school age youngsters in the United States are unprotected against polio, measles, rubella, diphtheria, pertussis (whooping cough), and tetanus, and

WHEREAS, this age group accounts for the greatest percentage of both cases and deaths from these diseases, and

WHEREAS, a host of public and private agencies, voluntary service groups, pharmaceutical firms, and the U.S. Public Health Service's Center for Disease Control, have joined together to carry out a two-phased campaign directed at private and public health care providers and parents for the purpose of increasing immunity levels among the inadequately and unimmunized pre-school age population, and

WHEREAS, the President of the United States has designated October, 1973 as National Immunization Action Month;

NOW THEREFORE, I, Otis R. Bowen, Governor of the State of Indiana, do hereby proclaim the month of October, 1973, as

**IMMUNIZATION ACTION MONTH**

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... from the Proclamation issued by Governor Bowen on September 4, 1973.



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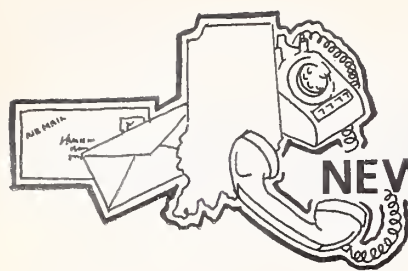


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## NEWS NOTES

### Hoosier Physicians Honored For Deeds, Careers, Service

News of the honoring of a number of Indiana physicians in various ways and for different reasons has been featured in Hoosier newspapers recently.

A new residence hall presently under construction at Gibault School for Boys will be named to honor **Dr. William C. Kunkler**, Terre Haute, who served as the school doctor for 37 years.

**Dr. F. E. Keeling**, Portland, who recently retired after a long career in general practice and as a pediatrician, was recognized at a dinner sponsored by the Medical Staff of the Jay County Hospital.

The Muncie Community Schools presented a plaque of recognition to **Dr. Tom Botkin** in appreciation for his services as school physician for the past 25 years.

**Dr. Virgil Scheurich**, who has practiced medicine at Oxford for 36 years, "has been honored by a grateful community, and a hospital in which he has treated patients . . . reaps the benefits," according to a recent story of the *Lafayette Leader*. Citizens of Oxford and the surrounding area have honored him by furnishing a patient room at Home Hospital, Lafayette.

The Springs Valley Exchange Club has named **Dr. B. E. Sugarman**, French Lick, recipient of the Golden Deeds Award for 1973. Selection of the recipient is made on the basis of a "significant contribution to the community in the spirit of unselfish service to others."

Special recognition was given **Dr. Louis Schneider**, Fort Wayne, when members of the St. Joseph's Hospital Medical Staff who have held staff membership for 25 years or more were honored recently.

Among others honored at the second annual Doctor's Recognition Dinner at the Fort Wayne Country Club were **Drs. Harry Garton, Charles Cooney, Joseph Baltes, Robert Brosius, Walter Rissing, Paul Stier, George Lenk, Lawrence Mueller, S. C. Michaelis, Herman Haffner, Arthur Hoffman, Richard Kent, Robert Lohman, John Nill, Robert Schmoll, Richard Stauffer, Floyd Walker, Roland Wilson, Chester Warfield, Emory Hamilton and Frederic Schoen.**

Patients and friends of **Dr. Irvin E. Huckleberry**, Salem, have chosen to honor "Dr. Huck" by naming a new wing of the Washington County Memorial Hospital the "Dr. Huckleberry Addition." Dr. Huckleberry, who obtained his Indiana medical license in 1917, is an ISMA Senior Member and a member of the Fifty Year Club.

**Dr. Leo R. Radigan**, Merrillville, has been appointed an Associate Professor of Surgery at the Indiana University Medical Center. A 1947 graduate of I.U.S.M., Dr. Radigan had a five-

year residency in surgery at the University. He has served at the National Heart Institute in Bethesda, the University of Leeds in England, the V.A. Hospital in Indianapolis, and at Wesley Memorial Hospital in Chicago. For the last 13 years he has been in private practice in Gary.

**Dr. Lester D. Bibler**, Indianapolis, was chosen to serve as a delegate from the Eleventh District of the American Legion Department of Indiana to the National Legion Convention in Hawaii and he was also named the Indiana representative on the National Convention of Hospitals and Medical Services Committee.

Another honor that carried with it a great deal of work was the appointment of **Dr. Rose Sison, Terre Haute**, as co-chairman of the Wabash Valley area fund-raising efforts for the Muscular Dystrophy Association in connection with the Jerry Lewis Labor Day Telethon. This year's muscular dystrophy poster child is a patient of Dr. Sison.

Seven area physicians who have served on the staff of the Elkhart General Hospital for 25 years or more were honored at an appreciation dinner at the Elcona Country Club recently. Those honored were: **Drs. Page Spray, William Stubbins, Leon Chandler, Robert Craig, Robert Denham, Jr., Hugh Miller, Jr., and George Paine.**

**Dr. John Read**, Chesterton, was presented with a Business Community Award by the Westchester Chamber of Commerce for his new medical building.

His work in supporting the habitual offender law that passed the 1973 legislature was cited by the Independent Insurance Association as the reason for presenting a plaque to **Dr. Robert Walker**, Bloomington general practitioner who is on the emergency room staff of the Bloomington Hospital.

**Dr. Robert A. Craig**, Syracuse, was recently elected president of the Lakeland Community School Corporation.

### Creator of Syphilis Test Dies

**Dr. L. Y. Mazzini**, 79, former Indiana University pathologist-serologist who discovered a syphilis test that bears his name, died June 23 in Fort Lauderdale, Fla., where he had been living in retirement.

Dr. Mazzini was chief serologist for the Indiana State Board of Health, a post he held for more than 20 years, and a professor at the I.U. School of Medicine when he developed the high speed blood test for syphilis in 1938. Proceeds of his multimillion dollar discovery were donated to the Indiana University Foundation.

A native of Lima, Peru, Dr. Mazzini received his medical education at I.U. He also served as special consultant to the U.S. Public Health Service and the Army, which applied his test to thousands of World War II draftees and recruits.

### Dr. Reid Named to AMA Task Force

**Dr. Robert M. Reid**, Indianapolis, has been asked to serve on the AMA Consulting Task Force for Data Control Processing and Storage.



## College of Radiology Offers Films

The American College of Radiology has published a pamphlet which lists medical movies which are available from the College for physicians for use in postgraduate training. The material includes scientific films, a cancer management series, public relations films and slide sets. A copy of the pamphlet may be obtained by writing the College at 20 N. Wacker Drive, Chicago 60606.

## Lilly Makes Grant to SAMA

Eli Lilly has made a \$20,000 grant to the Student American Medical Association for its National Information Center which is helping medical students acquire information about many important issues. Seminar topics are selected by SAMA questionnaire and include many socio-economic subjects.

## Nurses and Medical Assistants Urged to Attend Oct. 11 Seminar

The American Association of Medical Assistants, Inc., Indiana Society, is anticipating a bountiful year ahead filled with educational opportunities for all Indiana nurses and medical assistants, according to Mrs. Neva Y. Arnold, Indianapolis, Society president.

The newest venture will be an all-day seminar, October 11, 1973, at the ISMA Convention, and it is hoped that all physicians will support this seminar by encouraging their office personnel to attend this continuing education session.

The AAMA, Inc. National Convention entitled "Pathways to Monumental Goals," will be held October 21-26, 1973, at the Shoreham Hotel in Washington, D.C. The Indiana Society is sponsoring two of the 70 British medical assistants that will be in attendance. The program includes many authorities in the field of education and medicine.

The certifying examination for medical assistants is becoming more popular among M.A.'s and their employers in Indiana. Six more Hoosier assistants will receive their coveted C.M.A. pin at the National Convention, making a total of 22 C.M.A.s in Indiana. Of the 859 who took the test in the U.S. this year, 41% passed. Every day more Indiana physicians are realizing the benefits to their practice when their employees study for the examination, Mrs. Arnold said.

## Announce TV Documentary Series On Five Total Medical Conditions

The Public Broadcasting Service is sponsoring a five-part television documentary series, "The Killers," covering five fatal medical conditions: cancer, heart disease, genetic defects, pulmonary disease, and trauma. The series, which will begin in November, will be broadcast in the four succeeding months. The program is underwritten by Bristol-Myers. Local stations WTIU-Ch 30 Bloomington, WNIN-Ch 9 Evansville, WFYI-Ch 20 Indianapolis, WIPB-Ch 49 Muncie, WCAE-Ch 50 St. John, and WVUT-Ch 22 Vincennes will schedule the telecasts. The dates are November 19, December 17, January 14, February 11 and March 11. The five diseases covered are the cause of three out of four deaths in the U.S. The series is designed to acquaint the public about prevention, early detection and treatment. All public service organizations will be asked to aid in promoting public viewing.

## Pfizer Underwriting VD Campaign

The Advertising Council and the American Social Health Association are conducting a public education campaign on venereal disease. Public service commercials urge consumers to seek VD information from pharmacies and health clinics. Pfizer Laboratories is underwriting production costs for the program and is distributing pamphlets on VD cure and prevention to pharmacists.

## Medical Office Condominium Planned

A high quality medical office condominium is planned for a choice location in northwest Marion County close to the intersection of Highway 421 and Interstate 465, near new St. Vincent Hospital. The Innsbruck Development Corporation is pioneering the medical office condominium for doctors, dentists and associated professionals in the medical field. The possibilities of utilizing condominium ownership as a trust fund vehicle, as a personal investment and as an opportunity for income tax savings are emphasized in the explanatory literature which announces the new building.

## Hoosier Congressman Honored

Congressman Bill Hudnut of the 11th Indiana District is acting as the Assistant Minority Floor Leader during the fall session of Congress.

Continued



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## Governor Names M.D.s to Boards

Among recent appointments made by **Governor Otis Bowen** of Hoosier physicians to state boards and committees are the following:

**Dr. Dwight W. Schuster, Indianapolis**, to the Central State Hospital Advisory Committee;

**Dr. John O. Butler, Indianapolis**, to the Hospital Licensing and Regulating Council as an ex officio member;

**Dr. Fred Daugherty, Crawfordsville**, to the Indiana State Board of Registration and Education of Health Facility Administrators;

**Dr. J. William Wright, Jr., Indianapolis**, was reappointed to a four-year term on the Hearing Aid Dealer Advisory Committee;

**Dr. Leonard W. Neal, Hammond**, to the Indiana Health Facilities Council, and

**Dr. Harry Stout, Frankfort**, to the Standardbred Board of Regulations (a 1973 law created the six-member board to promote the standardbred horse industry in Indiana).

**Dr. Nathan L. Salon, Fort Wayne**, has been appointed to his fifth term as a member of the Indiana State Commission on the Aging and Aged. He was a charter member of the Commission.

## Dr. Blackburn Elected Museum Director

**Dr. Howard Blackburn, Noblesville**, has been named a director of the Indiana Museum of Transport and Communication. He is a former president of the museum board.

## Gary to Host Sickle Cell Symposium

The first scientific symposium for sickle cell disease in Indiana and in the Chicago area will be held in Gary Oct. 8. Sponsors of the program are Indiana University Northwest, the Northwest Indiana Sickle Cell Foundation and Gary Methodist Hospital. **Dr. Wei-Ping Loh**, chief pathologist at Methodist Hospital, is on the planning committee for the all-day meeting.

## Competes in Terre Haute Marathon

**Dr. James Maroc, Munster**, participated in the second annual Terre Haute Marathon and finished 102nd out of approximately 200.

"I don't run to win," Maroc said, "but rather I'm in it to finish the race and know at age 41 I can still do it." Ever since he started running five years ago, Dr. Maroc tries to run every day, although sometimes he can't find time to run.

"Sometimes I have run after midnight and at 5:00 a.m. Distance isn't important," Maroc said. "I run as much as I have time for."

## Doctor-Photographer Featured In Modern Photography Magazine

**Dr. Robert F. Green, Fort Wayne** psychiatrist, is the subject of a series of columns in current editions of *Modern Photography* magazine because of his interest in and preservation of the carbonyl process of photographic printing. He is

credited with saving from extinction the process which has been universally described as the most beautiful of all photographic processes.

The magazine's editor said that his interest in the process is its beauty and permanence. "We are writing our history in invisible ink," he said. "Most pictures are being taken in color now and the prints will not last. Carbonyl prints last as long as oil paintings with no changes whatever."

## Physician Openings in Welfare

The Department of Public Welfare has openings for physicians in its various divisions. Interested persons should contact **Dr. Irvin Wilkens**, 703 State Office Building, Indianapolis, whose telephone number is 317-633-4127.

## Another Hoosier M.D. Runs In Annual Boston Marathon

**Dr. George Branam, Muncie** pathologist, took part in the 1973 Boston Marathon, finishing 257th of the 1,340 who started the 26-mile grind. This was his third year to compete. Last year he placed 115th.

"I hadn't trained more than five miles in recent months and hadn't really planned to run this year until another doctor called me shortly before the marathon and urged me to go," Branam said.

The doctor he refers to, like Branam, is a member of the American Medical Joggers Association. The group was founded to encourage physicians to run and this year about 50 members turned out at Boston for the marathon.

Branam said it was the hottest day for a Boston Marathon since the late 1880s and that numerous runners became exhausted.

*The Journal* reported in July that **Dr. A. M. Hudson, Connersville**, also participated in and finished the race.

## Dr. Encinas Flight Winner

**Dr. Senen J. Encinas, English**, was first place winner in the consolation flight in the U.S. Medical Open Golf Tournament held July 16-22 at Hershey, Pa.

## Dr. Ridolfo Promoted

**Dr. Anthony S. Ridolfo, Indianapolis**, has been promoted to senior clinical pharmacologist by Eli Lilly and Company. He will continue his work in the Lilly Laboratory for Clinical Research at Marion County General Hospital.

## Fire Protection Booklets Offered

The National Fire Protection Association announces a publication "Hazardous Chemicals Data," 292 pages, for sale at \$3.50. Some 300 chemicals, 25 of which have never been covered before, are described with fire and explosion hazards, life hazard and fire fighting advice. Another booklet entitled "Standard for Nonflammable Medical Gas Systems" is on sale for \$1.00. "Standard for Fumigation" is listed at \$1.25. The Association address is 60 Batterymarch St., Boston 02110.



## College of Surgeons Sets Standards For Training of Surgeon's Assistants

The Bulletin of the American College of Surgeons for August carried a set of standards for the selection of and training of surgeon's assistants. This category is separate from that of operating room technician, the standards for which have been published by the AMA. The non-MD assistant "should be a skilled person qualified by academic and clinical training to provide patient services under the supervision and responsibility of a surgeon who is in turn responsible for the performance of that assistant." In a recent survey more than 8,000 of the 15,500 Fellows who responded to an inquiry indicated that they would utilize trained competent assistants.

## Pathlabs Names Research Director

Robert E. Curry, who will soon receive the Ph.D. degree in chemistry at Purdue, has been named director of research and development for Pathlabs Incorporated, Indianapolis.

## VA Promotes Warren Smith

Warren C. Smith, who at one time was a corrective therapist at the Indianapolis VA Hospital, and who is the immediate Past President of the American Corrective Therapy Association, has been named Chief of Corrective Therapy for the VA medical system, with office in Washington.

## Dr. Wishard Receives Guiteras Award

Dr. William N. Wishard, Jr., Indianapolis, was awarded the Ramon Guiteras Award for the most outstanding achievement in the practice of urology. The recognition honors the founder of the American Urological Association and is presented each year. A plaque and a cash award were given Dr. Wishard at a dinner held in New York City.

## Veterans Administration Names Two "Distinguished Physicians"

Dr. Maxwell Finland of Harvard Medical School and Dr. Jerome Conn of Michigan Medical School have been named Veterans Administration Distinguished Physicians. This brings to eight the number now active in this post, which is for physicians of exceptional professional stature during long and distinguished careers. Dr. Finland is particularly known in the field of antibiotic therapy and Dr. Conn for his work in diabetes and endocrinology.

## Pharmaceutical Foundation To Make 20 Starter Research Grants in 1973

The Pharmaceutical Manufacturers Foundation is continuing its program of starter research grants in pharmacology, clinical pharmacology and drug toxicology. Each grant is for \$5000 a year and extends over two years. Forty-three grants have been awarded in the program's first two years and this year there will be 20 more such awards.

Continued

# INDIANA STATE BOARD OF HEALTH

## MONTHLY REPORT — August 1973

Disease	Aug. 1973	July 1973	June 1973	Aug. 1972	Aug. 1971
Animal Bites	1165	1413	1849	1263	1305
Chickenpox	22	122	536	57	24
Conjunctivitis	190	304	252	176	138
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	72	34	33	18	20
Gonorrhea	1250	686	1291	907	647
Impetigo	227	259	125	174	128
Infectious Hepatitis	65	45	64	39	37
Infectious Mononucleosis	45	35	55	40	34
Influenza	1211	1063	1433	1138	279
Measles					
Rubeola	7	59	60	16	20
Rubella	12	21	69	33	51
Meningococcic Meningitis	0	0	2	0	1
Meningitis, Other	2	0	2	1	3
Mumps	34	83	82	35	57
Pertussis (Whooping Cough)	3	2	2	60	3
Pneumonia	257	297	467	205	158
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	655	738	1276	672	539
Syphilis					
Primary & Secondary	22	12	28	48	20
All Other Syphilis	116	65	127	83	100
Tinea Capitis	7	8	8	6	1
Tuberculosis (Active)	45	53	80	53	47



37 Hospitals Offering NCME Programs

The Network for Continuing Medical Education (NCME) produces three programs every two weeks which can be seen at 24 hospitals around the state on WAT 21, Indiana University School of Medicine's closed circuit television network.

The School of Medicine telecasts the programs beginning at 12 Noon (Indianapolis time) on Monday, Wednesday and Friday of the first week they're shown and on Tuesday and Thursday of the second week. In addition, 13 hospitals also subscribe to the NCME videotapes on their own, which gives them flexibility in playback times.

The current program schedule is listed below. For detailed information on viewing areas and playback times in your hospital, contact your Director of Medical Education or write to: WAT 21 Station Manager, University Hospital A116, I. U. School of Medicine, 1100 W. Michigan St., Indianapolis 46202.

The following is a list of the hospitals in Indiana making the NCME programs available either by closed circuit TV or videotape: Davis Clinic, Marion; Deaconess Hospital, Evansville; Elkhart General Hospital, Elkhart; Floyd County Memorial Hospital, New Albany; Gibson General Hospital,

Princeton; Good Samaritan Hospital, Vincennes; Goshen General Hospital, Goshen; Hendricks County Hospital, Danville; Howard Community Hospital, Kokomo; Indiana University Medical Center, Indianapolis; Lafayette Home Hospital, Inc., Lafayette, and La Porte Hospital, Inc., LaPorte.

Others providing the programs are:

Larue D. Carter Memorial Hospital, Indianapolis; Lutheran Hospital, Fort Wayne; Marion General Hospital, Marion; Memorial Hospital, South Bend; Methodist Hospital of Gary, Inc., Gary; Methodist Hospital of Indiana, Indianapolis; Our Lady of Mercy Hospital, Dyer; Parkview Memorial Hospital, Fort Wayne; Porter Memorial Hospital, Valparaiso; St. Anthony Hospital, Terre Haute; St. Catherine Hospital of East Chicago; St. Elizabeth Hospital, Lafayette; St. Francis Hospital, Beech Grove; St. Joseph Hospital, Fort Wayne, and St. Joseph's Hospital, South Bend.

In addition, the programs are provided by St. Joseph Memorial Hospital, Kokomo; St. Margaret Hospital, Hammond. St. Mary Mercy Hospital, Gary; St. Mary's Hospital, Evansville; St. Vincent Hospital, Indianapolis; South Bend Osteopathic Hospital, South Bend; Union Hospital Inc., Terre Haute; Veterans Administration Hospital, Indianapolis; Welborn Memorial Baptist Hospital, Evansville, and Veterans Administration Hospital, Fort Wayne.

Schedule of Upcoming NCME Programs

Here are the playing dates and upcoming programs to be distributed by The Network for Continuing Medical Education (NCME):

October 8—October 21 HOW TO OVERDIAGNOSE PULMONARY EMBOLISM, with Edward H. Morgan, M.D., Head of the Respiratory Disease Section, The Mason Clinic, Seattle, Wash.

WHAT YOUR AND YOUR PATIENT SHOULD KNOW ABOUT CORONARY ARTERIOGRAPHY, with F. Mason Sones, Jr., M.D., Director of Cardiovascular Medicine and Cardiac Laboratory; and Donald B. Effler, M.D., Director of the Department of Cardiovascular and Thoracic Surgery, both of The Cleveland Clinic.

ANTIBIOTIC MISADVENTURE: "THE CASE OF SUPERINFECTION, PAR EXCELLENCE," with Harold C. Neu, M.D., Chief of Infectious Diseases, Columbia University College of

Physicians and Surgeons, New York City. (A Drug Spotlight Program Feature.)

October 22-November 4 LAPAROSCOPIC STERILIZATION, with Thomas F. Dillon, M.D., Director of Obstetrics and Gynecology at Roosevelt Hospital and Professor of Obstetrics and Gynecology, Columbia University College of Physicians and Surgeons, New York City.

TRANSIENT ISCHEMIC ATTACK—THE HISTORY, with Clark Millikan, M.D., Senior Consultant in Neurology, and Professor of Neurology, The Mayo Clinic, Rochester, Minn.

TRANSIENT ISCHEMIC ATTACK—THE PHYSICAL, with Clark Millikan, M.D., Senior Consultant in Neurology and Professor of Neurology, The Mayo Clinic, Rochester, Minn.

For more information on NCME, write The Network for Continuing Medical Education, 15 Columbus Circle, New York 10023.



# New Members, Additions to ISMA Roster

*The Journal* welcomes the following physicians who have become members of the Indiana State Medical Association since the publication of the Roster of Members in the June issue:

## CLAY

Robert C. Oehler, M.D.  
R.R. 5  
Brazil 47834

## HANCOCK

Carl K. Matlock, M.D.  
302 South Main St.  
Shirley 47384

## HENDRICKS

R. Stephen Irwin, M.D.  
P.O. Box 345  
Roachdale 46172

## ST. JOSEPH

Frederick K. Dean, M.D.  
919 East Jefferson Blvd.  
South Bend 46622

## SULLIVAN

Russell James Dukes, M.D.  
Dugger 47848

## TIPPECANOE

John L. Horvath, Jr., M.D.  
3417 Beasley Drive  
Indianapolis 46222

Frederick C. Robinson, M.D.  
2600 Greenbush St.  
Lafayette 47904

## VANDERBURGH

William N. Floyd, Jr., M.D.  
2404 Pennsylvania Ave.  
Evansville 47721

Richard L. Gries, M.D.  
3700 Washington Ave.  
Evansville 47750

Gilbert A. Sartore, M.D.  
3700 Washington Ave.  
Evansville 47750

## VIGO

Ross D. Luther, M.D.  
628 Ash, Apt 50D  
Terre Haute 47804

## MARION

Ronald C. Hamaker, M.D. Surgery  
10821 Braewick Drive  
Carmel 46032

Frank T. Trainer, M.D. ORS  
2020 West 86th Street  
Indianapolis 46260

Richard N. Smith, M.D. Surgery  
5786 North New Jersey  
Indianapolis 46220

William A. Atz, M.D. ORS  
1021 Hume Mansur Bldg.  
Indianapolis 46204

Daniel F. Cooper, M.D. NS  
1815 North Capitol Ave.  
Indianapolis 46202

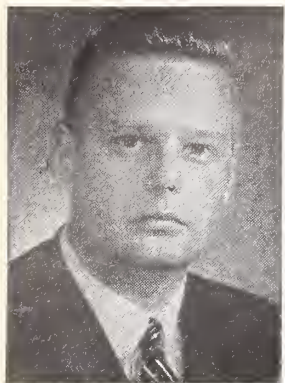
James J. McCallum, M.D. OPH  
8402 N. Harcourt Road  
Indianapolis 46260

Jeffrey A. Boester, M.D. Ob-Gyn  
7431 Countrybrook Drive  
Indianapolis 46260

Mohammad Reza Moltaji, M.D. OTO  
2725 Crescent Hill Lane  
Indianapolis 46208

A 20.4% increase in physicians' professional expenses and only a 5.2% increase in their net income between 1969 and 1970 are noted in the 1973 edition of the AMA's "Red Book," Reference Data on the Profile of Medical Practice. Produced by the AMA's Center for Health Services Research and Development, the "Red Book" and its companion "Blue Book," Reference Data on Socioeconomic Issues of Health, provide statistics on the health care industry. For copies of the 1973 editions, \$1.35 each, \$2.50 per set, write Order Dept, AMA Headquarters.





## TAX TIPS

by LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

If you are about to retire and you are going to receive benefits from an H.R. 10 (Keogh) Plan, then you'll have to determine whether it is more advantageous for you to receive your benefits in a lump-sum distribution or as an annuity. To help you make this decision, the I.R.S. has issued a new form, Form 4972. This form can be used to compute the amount of federal income tax which would be attributable to the lump-sum distribution which you could receive when you retire. After you have estimated that tax, then you can compare it with the amount of income tax which you would have to pay if you take your benefits as an annuity. You should have your lawyer call the I.R.S. for a supply of these forms—and have him fill one out for you.

\* \* \*

Every seller of real estate should ask his lawyer to read the case of *Warren Jones Co.*, 60 T.C. No. 70 (1973). In an extraordinary decision, the Tax Court held that an individual who sold some real estate under an installment contract did not have to report any gain from the sale until the installment payments

exceeded the adjusted basis of the real estate. That is, the Court held that the sale contract was *not* the equivalent of cash, and thus, the transaction was an "open" transaction, rather than a "closed" one. This is an extraordinary decision, because sales of real estate, under contracts which require fixed, definite payments of cash in the future, have been assumed to produce closed transactions. Thus, the I.R.S. has been quite successful in demanding that the gain from such sales be reported either in the year of sale or over the period during which the installment payments are made (under I.R.C. section 453). This case, if followed, can yield significant tax and economic savings to sellers of real estate—so take the time to bring it to the attention of your lawyer.

\* \* \*

Many of you have undoubtedly loaned money to a corporation for whom you were working. And, many of you have undoubtedly taken a *capital loss* deduction, for income tax purposes, when it was clear that the loan would not be repaid. However, a recent District Court held that the deduction may be an *ordinary loss* where the loans were made by the employee primarily to protect his job (and salary). The I.R.S. will certainly appeal the case, but you should tell your lawyer to file claims for refunds as a safeguard—and possible windfall. See *Kelson v. U.S.*, CCH § 73-5143.

\* \* \*

Taxpayers who owe amounts (for taxes, penalties and interest) for prior and current years and who make partial payments of such amounts to the I.R.S. frequently are the victims of, in my opinion, an unfair and undesirable practice

by the I.R.S. that is, if the I.R.S. is not instructed otherwise, then such partial payments are first applied against the tax, penalty, and interest that the taxpayer owes, commencing with the earliest period. This means that the partial payments are not applied to current tax obligations if there are amounts of penalties and interest owed for prior years.

As a result, the I.R.S. is able to assess additional penalties and interest against the current tax delinquencies. On the other hand, if the I.R.S. would automatically apply such partial payments to all tax obligations first, and then to penalties and interest, a taxpayer would not incur the additional penalties and interest.

To avoid this I.R.S. procedure (and undesirable result), a taxpayer may direct that his payments be applied to all his tax obligations first, before any payment is applied to penalties and interest. And, if such a direction is made, then the I.R.S. will honor it. See Rev. Rul. 73-304. Taxpayers who are not represented by counsel seldom know enough to make the direction—and it is my experience that I.R.S. agents do not inform taxpayers of this privilege.

\* \* \*

Audits of 1972 federal income tax returns indicate that very few taxpayers have earmarked either \$1 or \$2 of their income taxes so that the amount could be allocated to help finance the next Presidential campaign. Part of the reason may have been that the I.R.S. required a separate form to be attached to the return in order to make the allocation.



## FUTURE MEETINGS, SEMINARS, COURSES

### Western Cardiac Conference Arranged for November 2-3

The 20th Western Cardiac Conference will be held at the Cosmopolitan Hotel in Denver on November 2 and 3. The general theme of the Conference will be "Humane Aspects of Heart Attacks." Write Colorado Heart Association, 1375 Delaware St., Denver, 80204.

### Chicago Schedules 9th Annual "Frontiers of Medicine" Series

The University of Chicago announces the Ninth Series of "Frontiers of Medicine," for 1973-74. Each meeting occurs on the second Wednesday of each month from September 1973 through May 1974 at the Billings Hospital, 950 E. 59th St., Chicago. The subjects in order are: "Emergencies in Pediatrics and Pediatric Surgery: Diagnosis and Treatment," "Medical Complications of Pregnancy," "Arrhythmias," "Treatment of Recurrent Kidney Stones," "Sex and the Medical Practitioner," "Medical Emergencies," "Diagnosis and Management of Mammary Cancer," "Psychiatry and Drug Abuse," and "Pediatric Approach to the Prevention of Adult Disease." A fee of \$100

covers the entire series. Single sessions are \$15. For additional information write Frontiers of Medicine, University of Chicago, BHBox 451, 950 E. 59th St., Chicago 60637.

### University of Miami Announces Pediatric Nephrology Seminar

The University of Miami School of Medicine will conduct a Seminar in Pediatric Nephrology: Current Concepts in Diagnosis and Management, on January 2 to 5, 1974. The meeting will be held in the Eden Roc Hotel, Miami Beach. Write to Division of Continuing Education, P.O. Box 875 Biscayne Annex, Miami 33152.

### Childhood Cancer Conference Scheduled at Dallas in May

The American Cancer Society announces its National Conference on Childhood Cancer to be held at the Fairmount Hotel in Dallas, on May 16 to 18, 1974. The program is acceptable for 15 elective hours by the American Academy of Family Physicians. Inquire from the ACS at 219 E. 42nd St., New York City 10017.

## What's New?

Porelon has a hand stamp which needs no ink pad. A built-in supply of ink is molded into the microporous plastic from which the stamps are formed. Users have reported as many as 25,000 clean impressions. Several colors may be combined in a single, special stamp.

\* \* \*

Medcom has a new medical book for nurses, allied health professionals, premedical students and high school students who are interested in medicine. "Physiology of Medical Practice" is written in plain language to tell what a physician actually does in dealing with patient problems. Price—\$7.95.

\* \* \*

The Heintz Division of Kelsey-Hayes will soon have available a combination stainless steel fixture which is a swing-away water closet, a complete lavatory and a cabinet with a utility top. Installed in a hospital room it provides the lavatory facilities and a stool which can be used near the bed and yet be swung back into the cabinet out of sight between times. Eliminates taxing trips to the bathroom or equally strenuous experiences with the bedpan.

\* \* \*

Posey is introducing a new Posey vest with waist adjustment that cannot be changed by the patient. The

waist belt may be adjusted to fit the patient comfortably and can be secured under the bed so that the patient is unable to alter the size. Available in small, medium and large, in cotton or Breezeline.

\* \* \*

Parke-Davis introduced its new product, Loestrin, by way of a two-way closed circuit live and cassette television program originating in Detroit and beamed to 11 cities in the U.S. Approximately 950 sales representatives saw one hour of live broadcast, one hour of cassette tape, and then a live two-way question and answer period. Loestrin 1/20 is a new oral contraceptive containing 1 mg of norethindrone acetate and 20 mcg of ethinyl estradiol, plus seven tablets of 75 mg of ferrous fumarate to provide a continuous dosage regimen. It contains 60% less estrogen than any currently marketed combination oral contraceptives.

\* \* \*

Avionics Biomedical announces a new model of the Holter monitor which provides the physician with a depth of ECG data on his ambulatory patients which could not be obtained previously. The new Model 660 Electrocardioscanner scans the entire 24 hours of 2-channel data in just 12 minutes, twice as fast as other scanners.



## *The Woman's Auxiliary* Reports to ISMA

Of the many programs in which the Woman's Auxiliary is involved, one of the most successful and important is the fund raising effort for the American Medical Association Education and Research Foundation. To date over \$6 million has been raised with last year's total of \$965,000 making a new high for one year. The Woman's Auxiliary gave \$658,000 of this amount. Indiana's share of the 1972-73 total was more than \$25,000 (combined giving by Indiana physicians and their wives, with auxiliary members contributing over \$21,000). In twenty years the total giving nationally has increased from \$15,734 in 1951-52 to the present \$965,256, all voluntary contributions. An impressive total by any standards.



Aside from the fact that the fund raising efforts have been so successful, we're all interested to know what is done with the money when we get it. Some goes for scholarship loans, some for unrestricted grants to medical schools and some to other funds. Nationally this year funds for medical schools totaled approximately \$776,000. These funds are expended at the discretion of the dean of the medical school and are unrestricted grants because medical schools are always in need of flexible financial aid. AMA-ERF funds are given with no strings attached, and thus can solve the most pressing financial problem.

Medical schools need millions of additional dollars and contributors may designate their checks for the medical school of their choice, or they may donate to the general fund for medical schools, where monies are divided equally among all accredited medical schools at the end of the calendar year. Indiana's share in 1972 was over \$21,000 from this general fund.

The scholarship loan fund was instituted in 1962 and AMA-ERF has guaranteed 48,700 loans totaling over \$55,300,000 to students, interns and residents. Each student participating in this program must be recommended by the dean of his medical school. Here is how the loan fund works: A "loan security fund" is maintained, equal to at least 8% of all outstanding notes on deposit with banks participating in the program. The banks actually make the loans. A student may borrow up to \$1,500 in any 12-month period, up to a total of \$10,000 over seven years (provided educational loans from all sources do not exceed \$20,000). During his training, he must pay interest charges, but nothing on the principal. When he goes into practice, he starts paying back the full amount borrowed, but can take up to 10 years to do so. If a borrower defaults, the AMA-ERF buys his note from the bank and assumes the responsibility of collecting loan and interest. (Only a few hundred of these 48,000 loans have been defaulted, many because of death or illness). More than 60% of the loans have been made through Continental Illinois National Bank in Chicago, which helped the AMA begin the program in 1962; several other large banks now participate.

Most of AMA-ERF's money comes from physicians and their wives in Auxiliary. Other fund sources include bequests from individuals and foundations. For every dollar we give, we put to work \$12.50 through the banks who charge 1% above the prime rate for a long-term unsecured but guaranteed loan to help a future physician. These loans have been called "Loan of Last Resort" because they have been available to young men and women in medicine who have been unable to obtain a loan through other regular channels. It's a good way to help medicine help its own!

*Pat Strysdill*



# Deaths

## Ray T. Belding, M.D.

Dr. Ray T. Belding, 48, died July 31 in his Indianapolis home.

A 1952 graduate of the Indiana University School of Medicine, Dr. Belding had last been employed at a methadone clinic in Indianapolis. He had formerly been a resident anesthesiologist at the Marion County General Hospital and had practiced at Kokomo between 1959 and 1968.

## Robert E. Lyons, Jr., M.D.

Dr. Robert E. Lyons, Jr., Bloomington, died July 20 at the Bloomington Hospital. He was 69. He was a graduate of the Indiana University School of Medicine and interned at Methodist Hospital, Indianapolis, with a residency at the University of Chicago. He also studied at the National Heart Hospital, London, England. From 1940 to 1944 he served with the United States Army.

A former treasurer of the Owen-Monroe County Medical Society, Dr. Lyons was also a member of the American Medical Association.

## Charles W. Roller, M.D.

Dr. Charles W. Roller, 93, Indianapolis ophthalmologist who retired this year after 66 years of practice, died June 4.

He studied medicine at the Central College of Physicians and Surgeons, which became Indiana University School of Medicine, and the Eclectic Medical College of Indiana. He did postgraduate study at the Chicago Eye, Ear, Nose and Throat College in 1911 and 1943. Dr. Roller did further postgraduate work at the University of California and Woods-Pember Clinic, Janesville, Wis., where he studied ophthalmology.

The first doctor in Indianapolis to obtain a private pilot's license, he flew his own plane until he was 80.

Dr. Roller was a lieutenant in the Army Medical Corps during World War I and a major and state medical officer in the Civil Air Patrol during World War II.

He was a member of the American Medical Association, a Senior Member of the Marion County Medical Society, and became a member of the ISMA Fifty Year Club in 1956.

## Louis L. Teplinsky, M.D.

Dr. Louis L. Teplinsky, 69, died August 7 at St. Catherine

Hospital, East Chicago, where he had served as an anesthesiologist for 30 years.

He was a 1939 graduate of the Marquette School of Medicine, obtaining his Indiana license and membership in the Lake County Medical Society the following year. Dr. Teplinsky interned at St. Catherine Hospital and served a residency at the Illinois Research and Educational Hospital, Chicago. During World War II he served in the European Theater with the Army Medical Corps.

A diplomate of the American Board of Anesthesiology, Dr. Teplinsky was also a Fellow of the American College of Anesthetists, and the American Medical Association.

## Verne L. Turley, M.D.

Dr. Verne L. Turley, who had practiced medicine at Fowler for 50 years, died July 10 at home. He was 80.

A 1922 graduate of the Indiana University School of Medicine, he practiced one year at Galveston, moving to Fowler in 1923.

Dr. Turley had served as a delegate to the Indiana State Medical Association's Annual Meeting a number of times and became a member of its Fifty Year Club in 1971. He was a Senior Member of the ISMA and was also a member of the Benton County Medical Society and the American Medical Association.

## Philip E. Yunker, M.D.

Dr. Philip E. Yunker, 65, Howe, died August 18 in the Goshen General Hospital after an extended illness. He had practiced medicine and surgery in Howe since 1951, moving to Howe from Evansville where he had practiced since 1935. During World War II he served four years with the U. S. Army in New Guinea, later taking a cadre to the Philippines, where he helped open the 248th General Hospital in Manila.

He interned at the Indiana University hospitals in Indianapolis after graduation from the I.U. Medical School in 1932 and was a resident at St. Mary's Hospital, Evansville from 1933 to 1935.

Dr. Yunker was LaGrange County Health Officer for more than 15 years, was a past president of the staff of both the LaGrange and Sturgis, Mich., hospitals and of the LaGrange County Medical Society. He served for many years as a delegate from his county society to the ISMA Annual Meeting; he was also a member of the American Medical Association.



# County, District News

## Tenth District

At the annual meeting held on September 5, the following officers were elected to serve the Tenth District for the coming year: Dr. Mario D. Mansueto, Munster, president, and Dr. James R. Brown, Valparaiso, secretary.

## Fayette-Franklin

Dr. A. E. Angeles, Connersville, has been elected president of the Fayette-Franklin County Medical Society, and Dr. Abou Mazdai, also of Connersville, is the new secretary.

## Lawrence

Dr. John E. Pless is the new president of the Lawrence County Medical Society, with Dr. Guy Waldo as president-elect, Dr. James L. Mount, delegate, Dr. Florian Dino, alternate, and Dr. Reid C. Crosby, secretary-treasurer. All are of Bedford.

## Montgomery

Elected in May, the following new officers of the Montgomery County Medical Society took office September 1: Dr. Paul E. Ludwig, president; Dr. James

Stephens, vice president; Dr. Wesley Shannon secretary-treasurer (re-elected); Dr. Richard Eggers, delegate, and Dr. J. M. Kirtley, alternate.

## Wayne-Union

New officers recently chosen by the Wayne-Union County Medical Society are: Dr. Frank Adney, president; Dr. Glen Ramsdell, president-elect; Dr. Frank Deanovic, secretary; Dr. Charles Farmer, treasurer; Drs. Tom S. Shields and James Daggy, delegate and alternate from Wayne County, and Dr. Fred Shepard, delegate from Union County.

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## From The Journal 50 Years Ago

Concerning the method of anesthesia, without entering into any discussion of the merits of any particular agent, we have come to believe that, in general, one should always endeavor to produce the necessary anesthesia for the surgery at hand by the use of the minimal amount of anesthesia agent. Our colleague, Dr. Guedel, of Indianapolis, in his published work on "Third Stage Ether Anesthesia" has marked a notable advance in our knowledge of the possibilities in lighter anesthesia, and has given impetus to much thought and research leading to still further developments. However, only through the hearty co-operation of the surgeon can the best results along these lines be attained. Both surgeon and anesthetist must know, and equally well understand, how far they can go, and when each must give in to the other. The surgeon who has not, cannot or will not learn something of Crile's anoci-association, and then use it in adaptable cases, is overlooking a valuable aid to his technique. The blocking of the afferent nerve path from the site of trauma of the brain tends to prevent shock, produces better relaxation and is an essential in the better type anesthesia.

If the case has been studied thoroughly in all its clinical manifestations, the surgical team will have a well-developed plan **before** operation. This is of prime importance; it avoids delay and fosters action, which benefits should accrue to the patient. The surgeon should be prompt in his recognition of gross pathology; skillful, gentle and deft in exploration; a master of the art of sharp dissection; and perfected in the mechanics of surgical technique. Blood pressure readings during anesthesia prove conclusively that there is nothing more damaging than rough handling of the tissues; blunt dissection, mauling, pulling, pawing, three or four hands, or five or six packs in the abdomen. The operating room is not exactly the place to study anatomy, pathology or surgical technique; the dissection or autopsy table is more appropriate. . . . Floyd T. Romberger, M.D., Lafayette, "Surgery and Surgical Technique," JISMA, October 1923.



# Medicine's men on the Hill.

Just who are they? They're the AMA's permanent representatives to Congress and a part of the AMA's Washington staff.

In the 92nd Congress, about 10% of all legislation introduced was health related—more than 2,500 bills. The AMA's representatives serve as the eyes, ears and voice for our profession on such legislation. Keeping in close contact with members of Congress and their staffs. Explaining and promoting our profession's views. Reporting on legislation. And providing legislators with resource material and information on medical and health subjects.

They're on the Hill to protect your interests,

lobbying to retain the basic principles of private practice in any government health program that might be enacted. Equally important, they lobby to insure the passage of constructive and workable health legislation for the public.

Sure, the AMA lobbies. We lobby for the rights and interests of our profession and for quality medical care for every American. By adding your voice, your support, we can be even more effective.

**Join us.**

**We can do much more together.**

American Medical Association  
535 N. Dearborn St./Chicago, Ill. 60610





# Association News

July 15, 1973

The meeting of the Board of Trustees was called to order at 9:00 a.m. by Chairman Wilhelmus in the headquarters building of the Association on Sunday, July 15, 1973. Roll call showed the following:

District	Trustee	
1	Gilbert M. Wilhelmus	Present
2	Paul W. Holtzman	Present
3	Eli Goodman	Present
4	Howard C. Jackson	Present
5	Cleon M. Schauwecker	Present
6	Paul M. Inlow	Present
7	John O. Butler	Absent
7	Joseph Ferrara	Absent
8	Richard Ingram	Present
9	William M. Sholty	Present
10	Vincent J. Santare	Absent
11	James A. Harshman	Present
12	William R. Clark	Present
13	G. Beach Gattman	Present

District	Alternate	
1	Raymond L. Newnum	Absent
2	Betty Dukes	Absent
3	Thomas Neathamer	Absent
4	William Blaisdell	Present
5	William G. Bannon	Absent
6	Glen Ward Lee	Present
7	Donald McCallum	Absent
7	John Pantzer, Jr.	Absent
8	Jack L. Alexander	Absent
9	Max N. Hoffman	Absent
10	Martin O'Neill	Present
11	Lloyd L. Hill	Absent
12	Walter Griest	Absent
13	Donald S. Chamberlain	Present

Officers		
James H. Gosman, president	Present	
Joseph Dukes, president-elect	Present	
Hugh K. Thatcher, treasurer	Present	
Arvine G. Popplewell, asst. treas.	Absent	
Frank B. Ramsey, editor, <i>Journal</i>	Present	

Executive Committee		
Donald H. Kerr, Chairman	Absent	

AMA Delegates and Alternate Delegates		
James A. Harshman	Present	
Eugene F. Senseny	Absent	
Malcolm O. Scamahorn	Absent	
Lowell H. Steen	Absent	
Jack E. Shields	Present	
A. Alan Fischer	Absent	
Ross L. Egger	Absent	
Kenneth O. Neumann	Present	
Thomas C. Tyrrell	Present	
Patrick J. V. Corcoran	Present	

## Guests

Peter R. Petrich, M.D.	Present
Don E. Wood, M.D.	Present
Robert Reid, M.D.	Present
Mr. Arthur Loftin	Present

## Staff

Robert Amick, field secretary	Present
John L. Walters, field sec.	Present
Howard Grindstaff, field sec.	Absent
Michael McDermott, Leg. asst.	Present
Ken Bush, adm. asst.	Absent
James A. Waggener, exec. sec.	Present
Mary Alice Cary	Present

## REPORT OF DR. WOOD

DR. WILHELMUS: The first item of business this morning will be a discussion by Dr. Donald Wood, our AMA Trustee.

DR. WOOD: Thank you Mr. Chairman and members of the Board.

Dr. Wood then proceeded to read the minutes from the National PSRO Council meeting held July 9 and 10 in Washington, D.C. He explained the issues at the national level so as to assist the Board in their deliberations regarding PSRO. He discussed Phases II, III, and IV which will not exempt physicians.

DR. WILHELMUS: Thank you Dr. Wood. Anyone have any questions?

## PHASE III 1/2 SIGNS

A discussion then ensued concerning the sign which is required under Phase III 1/2.

DR. SCHAUWECKER: If it is in order, I would make a motion that the State Association go ahead with the mechanics of making these signs available to the membership of this Association.

CHAIRMAN WILHELMUS: The motion has been seconded by Dr. Thatcher; any discussion? If not, all in favor say 'aye'; contrary, the same sign; the motion is carried.

## PSRO DISCUSSION

CHAIRMAN WILHELMUS: Our Secretary, Mr. Waggener, received a call from the Chicago Regional Office of HEW stating that they were to hold a meeting on July 24, which is a week from Tuesday, to set up a plan for designating PSRO areas for the state of Indiana. I, myself, do not feel and I am sure President Gosman does not feel like he could go down to this meeting and say this is the area we desire. We thought this Board should be the one to have the say now before we go ahead. Let's hear from Dr. Harshman on what AMA did at the New York meeting in regard to PSRO.

DR. HARSHMAN: The reference committee at the AMA first heard reports from the Board of Trustees; reports E and CC, and these reports were ordered filed. Then they took up resolution 42 which, in essence, stated that only physicians should be involved in PSRO, and that regulations should be so written. The reference committee prepared a substitute resolution which was adopted by the House. This resolution reads as follows:

"RESOLVED that the Secretary of Health, Education, and Welfare be informed that the only organization which can give qualified peer review for physician's services to the patient, physicians, government, and taxpayer are those composed of practicing physicians, whether these are state or local groups; and

BE IT FURTHER RESOLVED, that since many of these practicing physician groups are functioning successfully with multiple approaches as peer review organizations, the regulations be so written to authorize the existing peer groups to continue their review as PSROs or as functioning units of PSROs, thus partially alleviating the unnecessary and costly implementation of new agencies as PSROs."

This is basically what happened in New York as far as PSRO is concerned.

CHAIRMAN WILHELMUS: Thank you Dr. Harshman; any questions?

DR. INGRAM: I would like for him to read the last resolution again.

The resolution was read again.

CHAIRMAN WILHELMUS: Thank you Dr. Harshman. Now we are leading up to the question of why we are here. What presentation shall we make to HEW on July 24? You have all received a copy of materials sent out by the regional office of HEW and I am hoping for discussion on these. Do you wish a statewide PSRO, one large unit umbrella over the whole state? Do you want regions, or what? Now I want to repeat that this is not saying that the State Medical Association will be in favor of PSROs at the October meeting but I think, as a state organization, we should assist certain people who desire PSRO and what areas they should be in.

The question then arose as to who is responsible for reporting to the House on PSRO.

DR. GOSMAN: It has been referred to the Future Planning Committee. It was sent back to them for their suggestion on what we should do. I think nothing has come out of the committee as yet.



A discussion then ensued concerning the PSRO activities and Dr. Wilhelmus called on Dr. Reid, who spoke as follows:

**DR. REID:** I think there is a basic misunderstanding of what PSRO means to us as practicing physicians and this is perhaps epitomized by the makeup of the task force on which I serve. With the exception of the chairman, Dr. Ronald Jackson, who is there by virtue of his directorship of NASA medical program and has had some private practice experience, I am the only member of that task force who has had one day in private practice.

We see it as a more elaborate and regulatory objectionable function of the utilization review concept. The real danger in this program is the reporting structure. I think most of you realize that by now. All these other plans such as Utah, MAI in Ohio and others all have their own ideas about it, but they all leave out the real guts of the program and that is what kind of daily report, where does it go, what can be done with it, and who will basically be in charge of it. The AMA as of last week, I think, is finally beginning to recognize this problem as realistic. From my point of view as a practicing physician, it becomes quite important because we will be an instrument in that reporting and we have a responsibility to our patients as to what is reported and what isn't. The point is simply we need an instrumentality between the regional or local reporting structure and HEW to determine what is appropriate data to be sent to the government. Once you divide yourselves up into little regional groups, denial of payment is a very effective instrument in enforcing abiding by their rules and regulations. We have lost all authority whatsoever if we simply abrogate totally our responsibility as doctors to protect their confidence and exercise our responsibilities to that record. If you do it on a statewide level you have a better control. It seems to me we are following exactly the same principle as Medicare, kind of delaying with half-hearted actions instead of looking at the real business of this legislation. The government made a real "goof" here as far as I am concerned and we have a real responsibility to protect our patient. To me, we have to move, we have to start talking about the approaches of repeal and look at the weakness of the law and begin to take some positive action and not apologize for our participation. I think it merits a very close inspection and positive

action by this Board.

A discussion then ensued among the members of the Board concerning the difference between a statewide umbrella-type PSRO forwarding the review mechanism back to the Board, district, or county society level and hospital level, and a statewide council. More discussion ensued concerning the question.

**CHAIRMAN WILHELMUS:** I think we have already stated our position on PSRO in the past, that this meeting is for the purpose of finding out whether, if one is established in Indiana, we want it on a statewide basis or regional PSROs.

Dr. Ingram discussed the differences between a regional-type PSRO and a statewide PSRO as it might affect his District.

The matter was further discussed by many.

Dr. Gosman then read a letter which he had written to Representative Hudnut after the visit to Washington in which he listed 16 points favoring a statewide PSRO system. He explained he would like to see regional utilization review committees established within the statewide organization, over all for coordination, and with the stipulation that when the regulations are set, should we find that this structure does not in any way do what the law says it is supposed to do, we make it public that this is not functioning according to the law.

Dr. Goodman then moved that: 1) this Board is already on record as being opposed to PSRO and the matter is to be considered by our House of Delegates sometime between October 6 and 11, 1973; however, 2) we must reply and thank HEW for their invitation to attend the July 24 meeting to present our policy; and 3) we should notify them that we are setting up, tentatively, a statewide umbrella organization; and 4) we are also setting up a special committee to point up the features of the PSRO law which are incompatible with good quality confidential care of our patients; and 5) we cannot formulate a position until after October 11, 1973, at which time we will contact them again. The motion was seconded.

**DR. GOSMAN:** I would move to amend the motion to add that we reserve the right to withdraw at any time if this does not accomplish what the law intends.

The amendment to the motion was then seconded, the motion was amended and put to a vote and carried.

**DR. THATCHER:** I would move that the Board of Trustees offer to the House of Delegates establishment of a corporation to provide a review mechanism at the state level which would, in turn, establish regional areas with responsibility for review, relying on established or existing hospital local review mechanisms as a primary base. Parameters would be established at the local level and regional areas would collect necessary data and refer this to the state corporation as a control base.

Motion was duly seconded, put to a vote and carried by a roll call vote of 13 to 2.

**DR. SHIELDS:** I would move that we send to the members of the House of Delegates the available PSRO materials and articles that would be both pro and con. The motion was duly seconded by Dr. Goodman, put to a vote and carried. A suggestion was made that knowledgeable speakers be obtained for the special hearing to get both pro and con views on PSRO during the state meeting.

It was also suggested that Dr. Reid prepare a summary of his statements to the Board and that this summary be in the materials being mailed to persons interested in PSRO.

#### **CONTINUING MEDICAL EDUCATION**

**CHAIRMAN WILHELMUS:** We will now have a report from Dr. Corcoran, who is on the AMA committee discussing continuing medical education, relicensure and recertification.

**DR. CORCORAN:** I am distributing to you a reprint on continuing competence of physicians which is reprinted from JAMA September 13, 1971. I would ask for a definitive position which I could take to the national level. It was moved by Doctor Gosman, duly seconded, that the ISMA make it known to the Commission on Legislation that the Board wishes to emphasize and re-emphasize the fact that recertification of physicians is not necessary because of the peer review that is already instituted. The motion was put to a vote and carried.

#### **REPORT FROM MR. WAGGENER**

**CHAIRMAN WILHELMUS:** We will now have a report from Mr. Waggener.

Mr. Waggener reported that the Association had won its tax case and had received refunds amounting to \$27,651.43. Mr. Waggener also pointed out that the Woman's Auxiliary had requested that the Association pick up the \$350 tab for the Tuesday night program during the annual meeting.



It was moved by Dr. Gattman, seconded by Dr. Goodman and carried that the expense of \$350 be borne by the Association.

Mr. Waggener would like to have this Board establish a policy to clarify who is to receive the certificates for outgoing terms of office. Upon motion by Dr. Gosman, seconded by several, it was moved that all alternate trustees and the alternate AMA delegates, as well as the Commission and Committee chairman and members, be entitled to receive a certificate for term of service to the ISMA.

Dr. Goodman then suggested that the Commission or Committee member must have a minimum attendance requirement. Dr. Schauwecker then proposed an amendment that members must have at least a 50% attendance record.

Dr. Goodman then amended the amendment by "at least 50% attendance or upon recommendation of the Chairman." The motion with the amended amendment was put to a vote and carried.

#### **REQUEST OF DR. PETRICH**

**CHAIRMAN WILHELMUS:** I will now call on Dr. Petrich.

**DR. PETRICH:** I would like to have the Board empower Dr. Gosman, Dr. Harshman, Dr. Reid and myself to go to Ohio to study their MAI program.

Dr. Petrich went ahead to explain the operation of the program in Ohio and his contact with them. The matter was discussed by several and, upon a motion by Dr. Ingram and a second by Dr. Goodman, it was approved that these four go to Ohio to investigate the operation of MAI program. The motion was put to a vote and carried.

#### **PUBLIC INFORMATION COMMISSION REPORT**

**CHAIRMAN WILHELMUS:** We will now hear from Dr. Gosman, who has a report to make on behalf of Dr. Crane, Chairman of the Commission on Public Information.

Dr. Gosman then read the letter from Dr. Crane outlining his thinking for a public relations effort through a public speaking bureau and the cost. There was much discussion concerning the control of where the speeches were to be given, the type of audience, PR value, etc.

**DR. THATCHER:** I would move that we refer this request to the Finance Committee of the Board for further study and recommendation and then it be taken to the House of Delegates. The motion was duly seconded, put to a vote and carried.

#### **REPORT ON STATE DETENTION SYSTEM**

**CHAIRMAN WILHELMUS:** I will now recognize Dr. Gosman.

**DR. GOSMAN:** I have received a call from an attorney who heads up the Indiana Bar Association Commission to study the state detention system. It is funded by Eli Lilly and Co. He has requested that we supply some members of the ISMA to work with this commission because they feel the need of input from the physician on certain questions that are coming up. For instance, what really does solitary confinement do to an individual; what really does the sight of a uniform mean to a man, and so he asked me if we would be willing to get to this and what they do will be to meet on Friday, stay over night, and meet Saturday with all expenses paid. I, personally, feel that we should get involved in this type of thing, that the Governor is particularly interested in our detention system and what is happening to it. I would like the approval of this Board to go ahead and appoint two or three members who might be interested in this type of thing and, if you know of anyone in your area who would be interested in this program, I would like to have his name. A motion was duly made and seconded and carried that the President be authorized to appoint members to this commission.

#### **RENAL DIALYSIS PROGRAM**

The next item discussed by Dr. Gosman concerned the complaint of one member concerning the Federal Regulations governing the renal dialysis program.

#### **REPORT ON AMA MEETING**

**CHAIRMAN WILHELMUS:** We will now have a report from Dr. Harshman on the AMA meeting in New York.

Dr. Harshman then reported on the election of the various officers at the AMA level and explained some of the other events which took place during the New York meeting and congratulated the delegates and the officers and staff for their coordination of activities during the session.

Dr. Harshman then explained that Dr. Wood would be up for re-election in June of 1974 to another term on the Board of Trustees and moved that the Board approve the ISMA supporting Dr. Wood for this post.

The motion was duly seconded, put to vote and carried.

#### **MINUTES OF MAY 20 and JUNE 17 MEETING**

**CHAIRMAN WILHELMUS:** We will now take up the approval or rejection of the minutes of the May 20 and June 17 meetings.

**DR. HARSHMAN:** I would move that the minutes be adopted as printed. The motion was duly seconded, put to a vote and carried.

**DR. GOSMAN:** I would move at the present time that the Board return all of the tabled items, especially on PSRO, to the table. The motion was duly seconded, put to vote and carried.

**CHAIRMAN WILHELMUS:** Before moving on to the Executive Session, if agreeable, we will establish the next meeting of the board for Sunday, September 9, 1973.

The Board then moved into Executive session.

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Descriptions of over 1,200 drugs will be contained in the second edition of the AMA's compendium of prescription drugs, AMA Drug Evaluations. The AMA's Dept. of Drugs has prepared the new volume with the advice of over 300 consultants. It is being published under contract with Publishing Sciences Group, Inc. The cost is \$16.50 for AMA members and students and \$22 for non-members and institutions. Special prices are available for state medical societies wishing to distribute the book free or to sell copies to their members. Direct orders and inquiries to Publishing Sciences Group, Inc., 411 Massachusetts Ave., Action, Mass. 01720.



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**EXCELLENT OPPORTUNITY** to work with mentally retarded. Diversified and challenging! Forty-hour week, Monday through Friday; one-half day off for one night call weekly and full day off for one weekend call every five weeks. Good salary with liberal fringe benefits. Write or call George W. Smith, Personnel Director, Fort Wayne State Hospital and Training Center, Fort Wayne, IN, 46805, Tel. No. 219-484-6621.

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**DIRECTOR OF UNIVERSITY STUDENT HEALTH SERVICE**—Indiana State University is seeking a staff physician and a Director of the University Student Health Service. Excellent facilities, good staff, 12,000 students, new laboratory, x-ray and pharmacy. Apply to John W. Truitt, Vice President for Student Affairs, Indiana State University, Terre Haute, Indiana 47809.

1973 ROSTERS AND YEARBOOKS are available. Send check for \$5.00 for the Yearbook (June issue) or \$3.00 for the Roster to: The Journal, ISMA, 3935 N. Meridian St., Indianapolis 46208.

## NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be consid-

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**PRECEDING** month of issue.



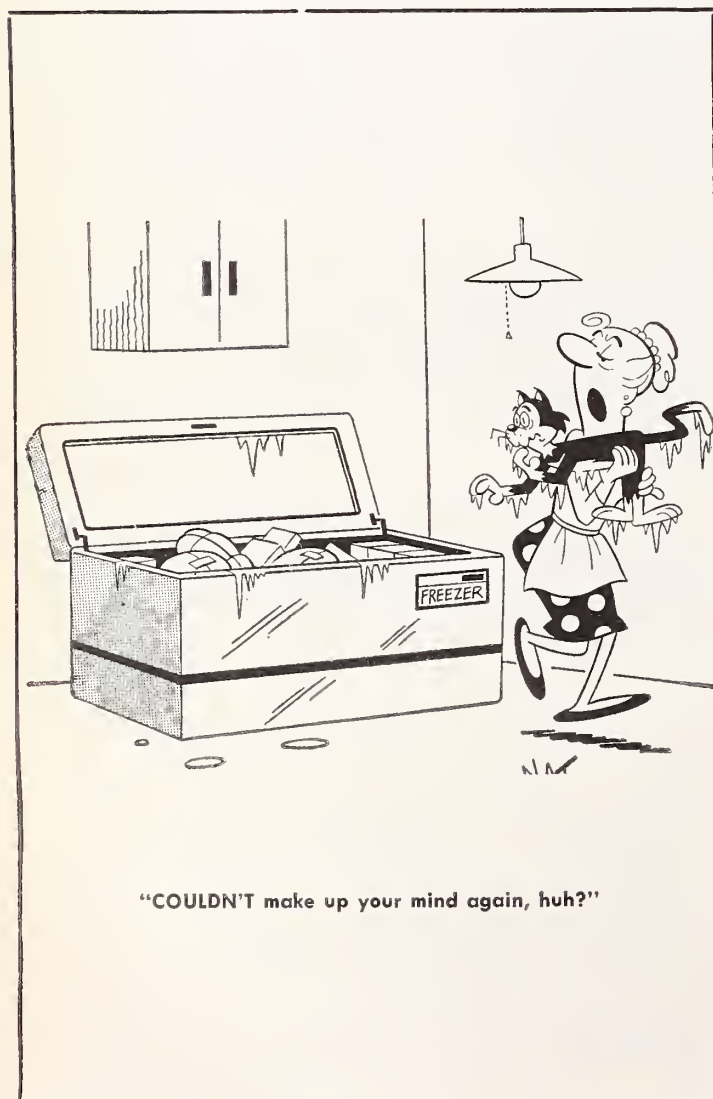
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Established by the Indiana State Medical Association for educational and scientific purposes, including an endowment fund for publication of **The Journal**.

Contributions made to the Foundation are deductible by donors in accordance with the Internal Revenue Code.

Bequests, legacies, devises, transfers or gifts to the Foundation are deductible for Federal estate and gift tax purposes.

The Foundation is an ideal recipient of gifts made in memory of deceased friends and relatives. A special Memorial Book is maintained to record such gifts. Special memorial funds may be established within the Foundation to honor individuals.



"COULDN'T make up your mind again, huh?"

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# The JOURNAL

OF THE INDIANA STATE  
MEDICAL ASSOCIATION

November 1973

Vol. 66 • No. 11 • Indianapolis, Indiana

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ST. FRANCIS HOSPITAL CENTER

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Everybody experiences psychic tension.



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Some people develop excessive psychic tension and need your counseling,



and a few may need counseling  
*and* the psychotropic action of Valium® (diazepam).



Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect.

**Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.



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Nutley, N.J. 07110

# Valium® (diazepam)

To help you manage excessive psychic tension



**White-Haines  
always gives  
you a  
little  
more.**



That was our way when we started 72 years ago. It still is. If you're entering practice we're ready with more of the help you need. The finest instruments and equipment. Frame selections second to none. Extra-care prescription service. Assistance in planning your new office. Helpful financing programs. Any need.

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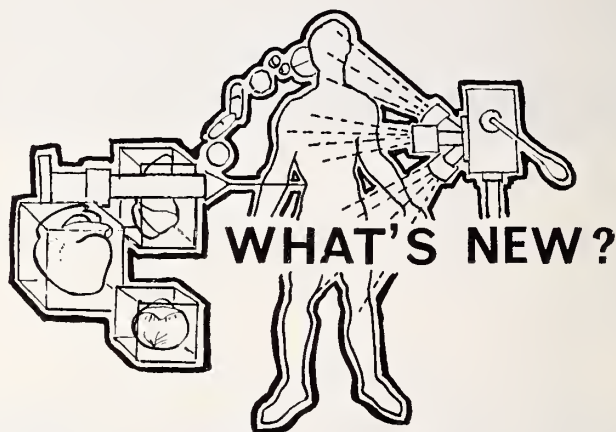
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Mead Johnson will market Questran (cholestyramine) for the lowering of serum cholesterol. Questran has been on the market since 1967 for relief of pruritus due to obstructive jaundice. The active agent is an anion exchange resin which binds bile acids in the GI tract, prevents their reabsorption and conversion into cholesterol. Clinical studies since 1963 have demonstrated the effectiveness in lowering cholesterol.

\* \* \*

Toshiba announces a new ultrasound system. Called the SSL-21A, it is marketed by Litton's Profexray International Corporation. It is a general purpose system utilizing low power and pulsed ultrasound energy to picture the size, location and condition of anatomical structures.

\* \* \*

Clin-Alert announces an airmail bulletin service for health care professionals to maintain current information on adverse drug reactions. Subscription price is \$25 per year. Quarterly cumulative indexes and a special binder are provided. Back issues are available from 1962.

\* \* \*

Micro Medical Records makes permanent laminated wallet-sized duplicate cardiograms for those patients who have an abnormal cardiogram and for whom a previous cardiogram would be of value in event of a newly developed acute situation.

\* \* \*

Ames announces a new three-way system for detection of urinary tract infection. Called MICROSTIX™ Reagent Strip, it consists of a chemical test for nitrite and two miniaturized culture tests which can indicate varying levels of bacteriuria. MICROSTIX is the first microbiological test strip to be introduced by Ames.

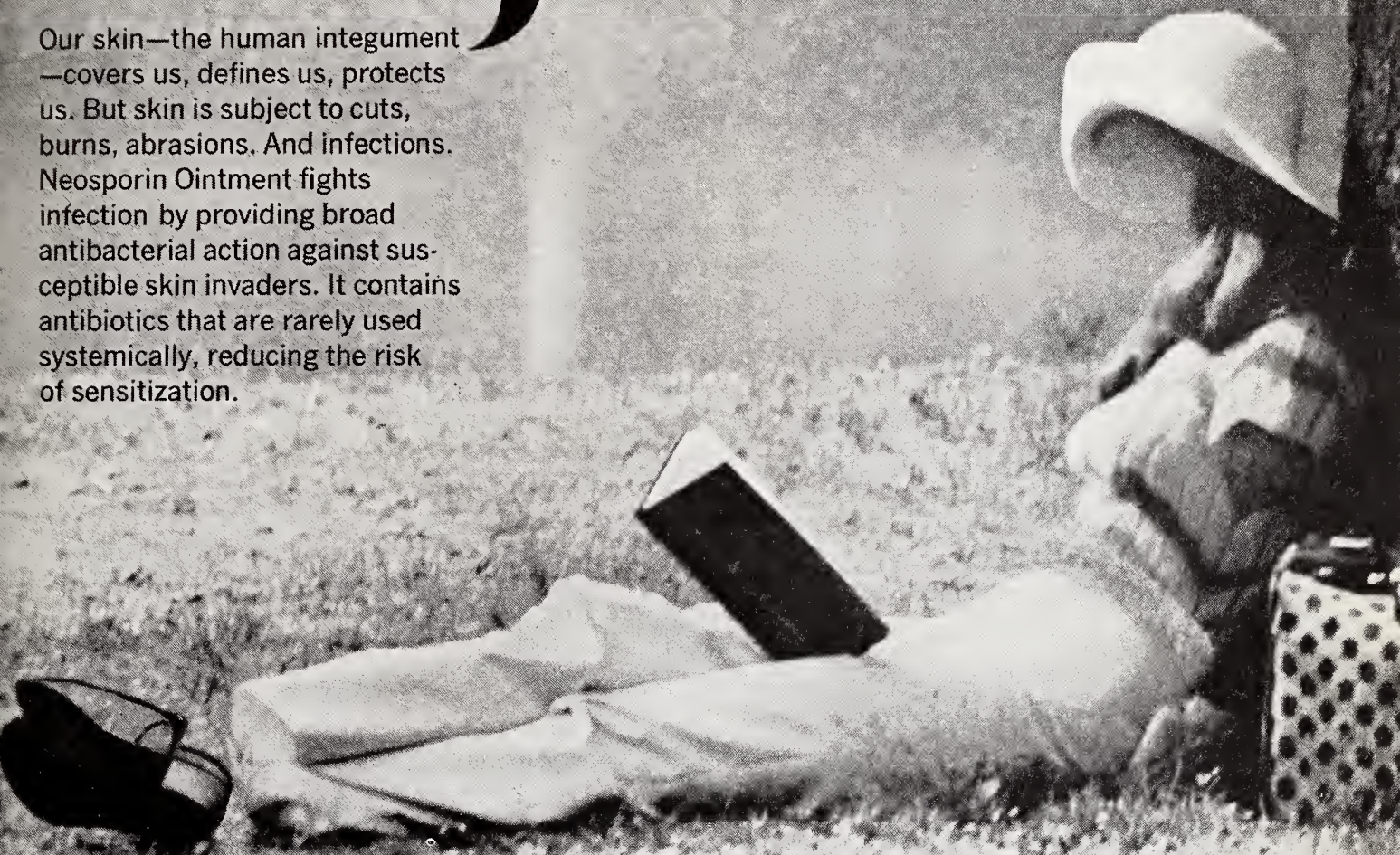
\* \* \*

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.



# Integument!

Our skin—the human integument—covers us, defines us, protects us. But skin is subject to cuts, burns, abrasions. And infections. Neosporin Ointment fights infection by providing broad antibacterial action against susceptible skin invaders. It contains antibiotics that are rarely used systemically, reducing the risk of sensitization.



**INDICATIONS:** *Therapeutically*, used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in:

- infected burns, skin grafts, surgical incisions, otitis externa
- primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia)
- secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis)
- traumatic lesions, inflamed or suppurating as a result of bacterial infection.

*Prophylactically*, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

**CONTRAINDICATIONS:** Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

**PRECAUTION:** As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

## NEOSPORIN<sup>®</sup> Ointment

(POLYMYXIN B-BACITRACIN-NEOMYCIN)

Each gram contains: Aerosporin<sup>®</sup> brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q.s. In tubes of 1 oz. and ½ oz. and ¼ oz. (approx.) foil packets.



Burroughs Wellcome Co.  
Research Triangle Park  
North Carolina 27709



Office of Publication

3935 N. Meridian, Indianapolis, Indiana 46208

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### EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 3266 N. Meridian St., Room 705, Indianapolis 46208. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.

Advertising rates will be furnished on request. Copy must be received by the 1st of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

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Our International Standard Serial Number is ISSN 0019-6770.

Indexed in Hospital Literature Index.





## acute arthritic inflammation...heat that freezes

In acute rheumatoid arthritis consider Tandearil. The anti-inflammatory action of Tandearil quickly helps reduce heat, pain, swelling, and stiffness. Results are usually seen in 3 or 4 days. Try it for a week when the symptoms defy aspirin control.

Remember that Tandearil is not a simple analgesic. It should not be used on patients responding to routine therapy. Before using, please read the prescribing information. It's summarized below.

## Tandearil® helps take the heat off oxyphenbutazone NF Geigy

Tablets of 100 mg.

**Important Note:** This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

**Indications:** Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

**Contraindications:** Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

**Warnings:** Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against po-

tential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

**Precautions:** The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

**Adverse Reactions:** This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia,

gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement. (B)98-146-800-F (10/71)

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals  
Division of CIBA-GEIGY Corporation  
Ardsley, New York 10502





# More than sleep..

your choice of sleep medication  
is wisely based on more than  
sleep-inducing potential

## sleep with relative safety

Chronic tolerance studies have confirmed the relative safety of Dalmane (flurazepam HCl); no depression of cardiac or respiratory function was noted in patients administered recommended or higher doses for as long as 90 consecutive nights.

In most instances when adverse reactions were reported, they were mild, infrequent and seldom required discontinuance of therapy. Morning "hang-over" with Dalmane has been relatively infrequent. Dizziness, drowsiness, lightheadedness and the like have been the side effects noted most frequently, particularly in the elderly and debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

## sleep for 7 to 8 hours without need to repeat dosage

No sleep medication has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia patients given one 30-mg capsule of Dalmane at bedtime, on average: fell asleep within 17 minutes, had fewer nighttime awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to repeat dosage during the night.



sleep with  
consistency

Dalmane (flurazepam HCl) is a distinctive sleep medication—a benzodiazepine specifically indicated for insomnia. It is not a barbiturate or methaqualone, nor is it related chemically to any other available hypnotic.

When your evaluation of insomnia indicates the need for a sleep medication, consider Dalmane—a single entity nonnarcotic, non-barbiturate agent proved effective and relatively safe for relief of insomnia.

Dalmane has been shown to be consistently effective even during consecutive nights of administration, with no need to increase dosage.

**DALMANE**<sup>®</sup>  
(flurazepam HCl)

**When restful sleep  
is indicated**

**One 30-mg capsule h.s. — usual adult dosage**  
(15 mg may suffice in some patients).

**One 15-mg capsule h.s. — initial dosage for elderly or debilitated patients.**

**Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:**

**Indications:** Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

**Contraindications:** Known hypersensitivity to flurazepam HCl.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

**Precautions:** In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

**Adverse Reactions:** Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

**Supplied:** Capsules containing 15 mg or 30 mg flurazepam HCl.



ROCHE LABORATORIES  
Div., Hoffmann-La Roche Inc.  
Nutley, New Jersey 07110



# **It's time for action to defend the laws and regulations that protect your patients against drug substitution.**

**These professional and trade organizations are united in supporting antisubstitution statutes and regulations:**

The American Academy of Dermatology

The Board of Directors of the  
American Academy of Family  
Physicians

The Executive Board of the  
American Academy of Neurology

The Committee on Drugs of the  
American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the  
American College of Obstetricians  
and Gynecologists

The Board of Regents of the  
American College of Physicians

The Board of Trustees of the  
American Dental Association

The Board of Trustees of the  
American Medical Association

The American Psychiatric Association

The Executive Committee of the  
National Association of Retail  
Druggists

The Board of Directors of the  
Pharmaceutical Manufacturers  
Association

The National Wholesale Druggists'  
Association





## Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage interprofessional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that

economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

*Pharmaceutical Manufacturers Association  
1155 Fifteenth Street, N.W., Washington, D. C. 20005*





# ROCHE announces new

# BACTRIM<sup>TM</sup>

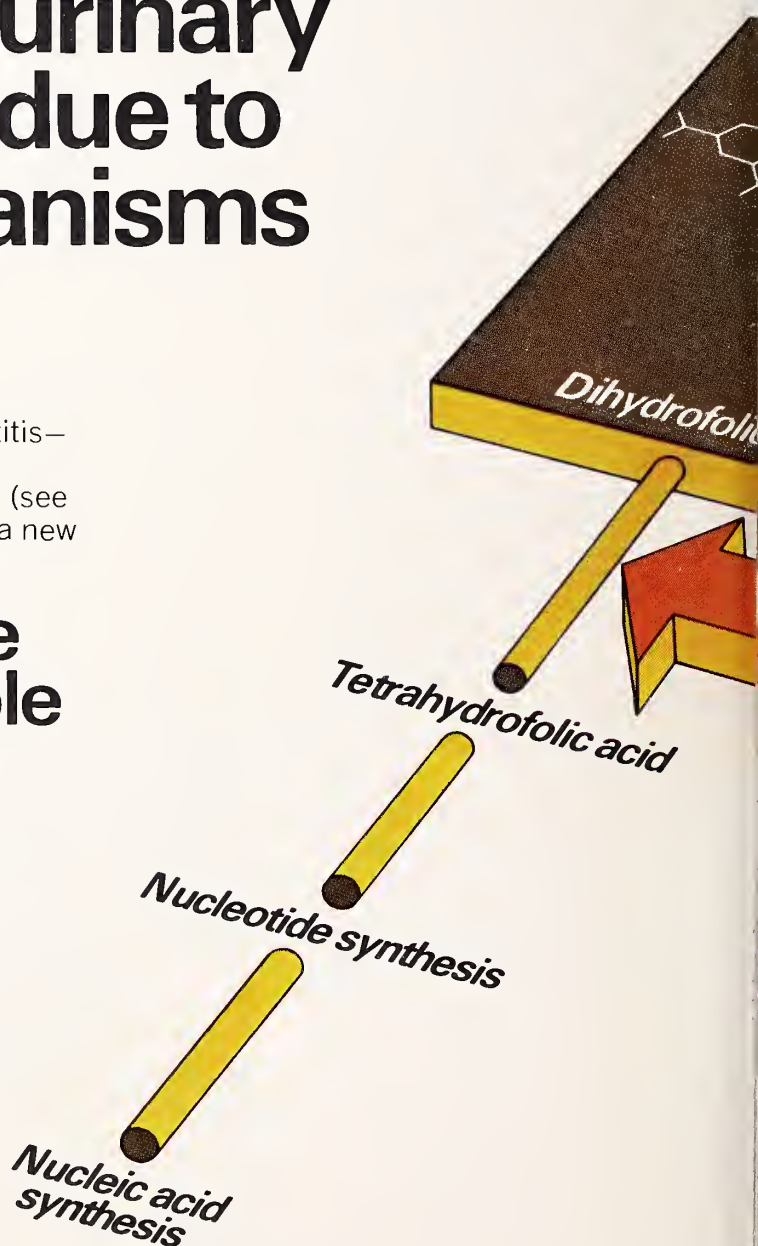
Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

## a new type of antibacterial for a two-pronged attack against chronic urinary tract infections due to susceptible organisms

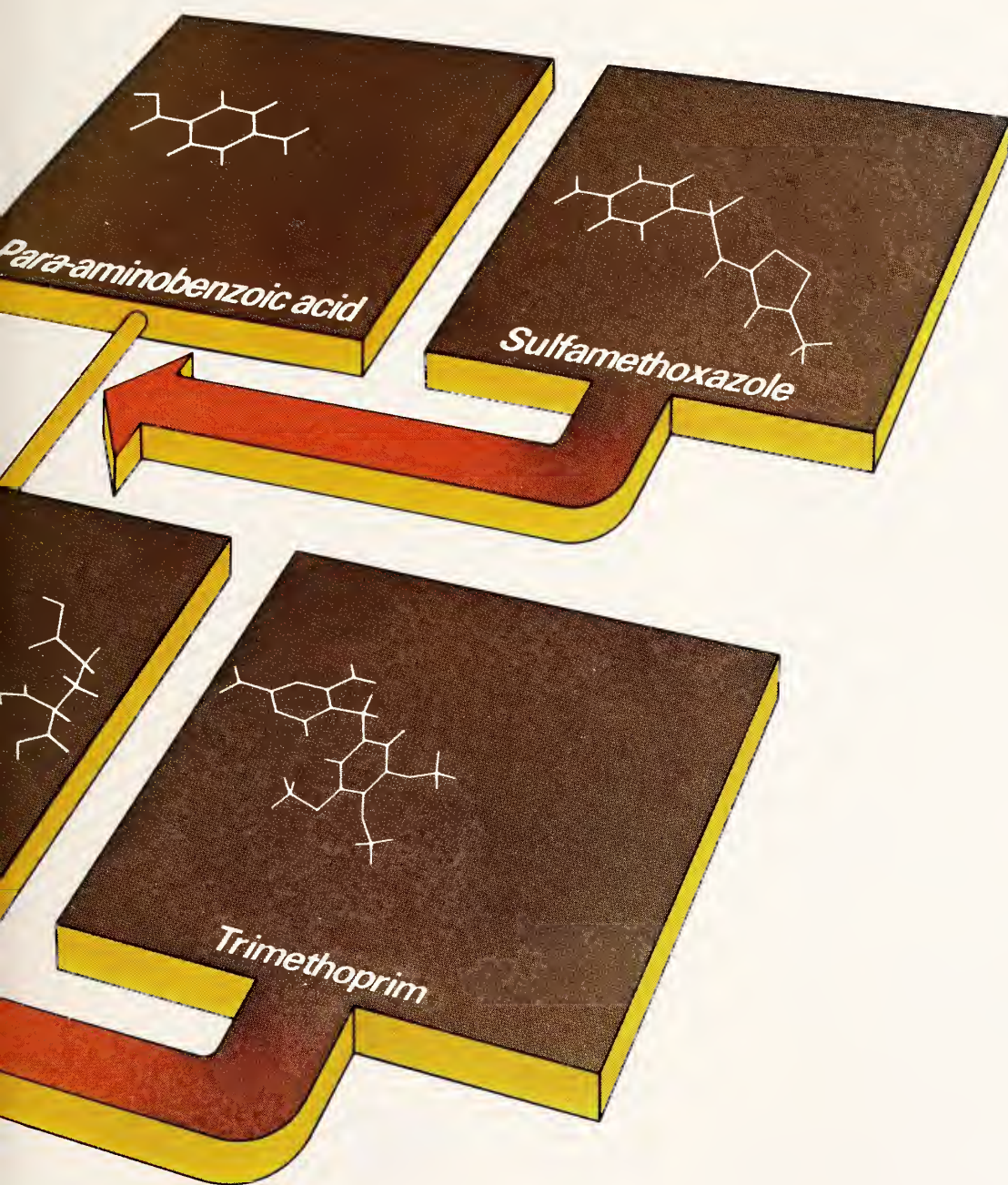
Bactrim is highly effective in the treatment of these infections — primarily pyelonephritis, pyelitis and cystitis — when due to susceptible organisms. This efficacy is related to the unique mode of action against bacteria (see illustration), an action that, in effect, makes Bactrim a new type of antibacterial.

### Bactrim interrupts the life cycle of susceptible bacteria

*Unique mode of action interrupts the life cycle at two important points, thereby impeding the production of nucleic acids and proteins essential to these bacteria. These consecutive interruptions occur because sulfamethoxazole and trimethoprim resemble naturally existing substrates. By competitive replacement of these substrates, they inhibit further synthesis.*







new **BACTRIM**<sup>T.M.</sup>

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

**for chronic urinary tract infections**

Before prescribing, please see complete product information on last page of advertisement.



## Excellent clinical response in chronic urinary tract infections even with obstructive complications

A multiclinic, double-blind study\* of response to a ten-day course of therapy in 471<sup>†</sup> patients with chronic urinary tract infections demonstrated the superiority of Bactrim. On the 10th day after initiation of therapy, 91.7% (of 168 patients) showed significant bacteriological response to Bactrim, compared with 81.2% (of 144 patients) to trimethoprim and 64.5% (of 155 patients) to sulfamethoxazole. More than half of these patients had obstructive complications.

## Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after a ten-day course of therapy with Bactrim, 68.4% of patients with chronic urinary tract infections *maintained* response for up to 42 consecutive days, compared with 59.7% with trimethoprim and 44.4% with sulfamethoxazole. These results are particularly noteworthy considering the number of patients with obstructive complications—cases regarded as being notoriously difficult to treat.

## Prescribing considerations

**Clinical Limitations:** Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections. Not recommended for children under twelve.

**Contraindications:** Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period.

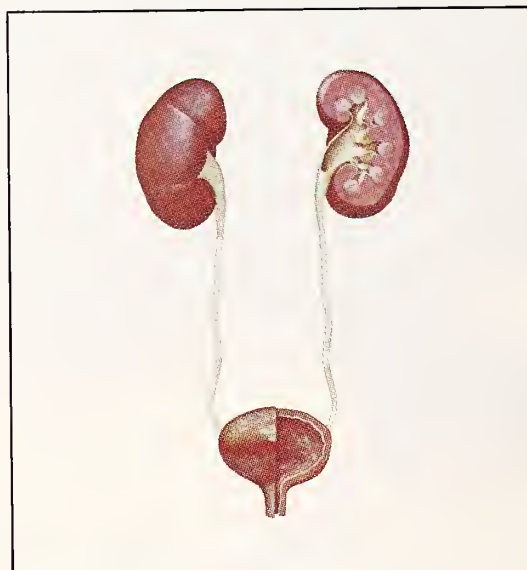
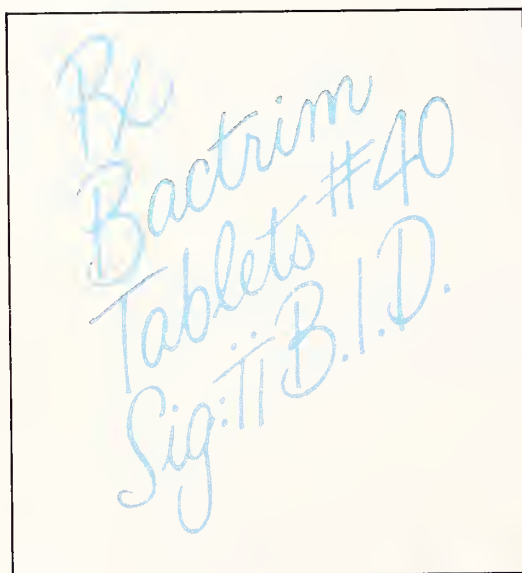
**Warnings and Precautions:** Both sulfamethoxazole and trimethoprim have been reported to interfere with hematopoiesis. Complete blood counts should be done frequently. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued. Bactrim should be given with caution to patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. Maintain adequate fluid intake. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

**Adverse Effects:** Among the most common side effects are nausea, vomiting, rash, leukopenia and elevations in SGOT and creatinine.

**Usual adult dosage: two tablets every twelve hours for 10 to 14 days; no loading dose required.**

\*Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110

<sup>†</sup>4 patients not available for evaluation at day 10.



new **BACTRIM** <sup>TM</sup>

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

**for chronic urinary tract infections**



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110

**Before prescribing, please consult complete product information on facing page.**



Complete Product Information:

**Description:** Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is N<sup>1</sup>-(5-methyl-3-isoxazolyl)sulfanilamide. It is an almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

**Actions: Microbiology:** Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with para-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

*In vitro* studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

*In vitro* serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa*. The following organisms are usually susceptible: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis* and indole-positive proteus species.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms (MIC—mcg/ml)				
Bacteria	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20)	
			TMP	SMX
<i>Escherichia coli</i>	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
<i>Proteus</i> spp. indole positive	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
<i>Proteus mirabilis</i>	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
<i>Klebsiella-Enterobacter</i>	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

**Human Pharmacology:** Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. On repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma decreases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than are the concentrations in the blood. When administered together as in Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

**Indications:** Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, and, less frequently, indole-positive proteus species).

**Important note:** Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.

**Contraindications:** Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction Studies).

**Warnings:** Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

**Precautions:** Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

**Adverse Reactions:** For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

**Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

**Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

**Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

**C.N.S. reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

**Miscellaneous reactions:** Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarthritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

**Dosage and Administration:** Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

**How Supplied:** Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

**Reproduction Studies:** In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

**BACTRIM**™  
Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110



# THE INDIANA STATE MEDICAL ASSOCIATION

3935 N. Meridian, Indianapolis 46208—Telephone 925-7545

ANNUAL CONVENTION—OCTOBER 7-9, 1974—Indianapolis

## OFFICERS FOR 1973-74

President—Joe Dukes, Dugger 47848  
President-Elect—Gilbert M. Wilhelmus, Evansville  
Treasurer—Hugh K. Thatcher, Jr., 4548 College Ave., Indianapolis 46205.

Assistant Treasurer—Arvine G. Popplewell, 960 Locke St., Indianapolis 46202  
Chairman of Executive Committee—Donald M. Kerr, 2900 W. 16th St., Bedford 47421  
Executive Secretary—Mr. James A. Waggener, 3935 N. Meridian, Indianapolis 46208.

## TRUSTEES

District	Term Expires
1—Gilbert M. Wilhelmus, Evansville	Oct. 1974
2—Paul W. Holtzman, Bloomington	Oct. 1975
3—Eli Goodman, Charlestown	Oct. 1976
4—Howard C. Jackson, Madison	Oct. 1974
5—Cleon M. Schauwecker, Greencastle	Oct. 1975
6—Paul M. Inlow, Shelbyville	Oct. 1976
7—John O. Butler, Indianapolis	Oct. 1974
8—Joseph F. Ferrara, Franklin	Oct. 1975
9—Richard Ingrom, Montpelier	Oct. 1973
10—William M. Sholty, Lafayette	Oct. 1976
11—Vincent J. Santare, Munster (Chairman)	Oct. 1974
12—James A. Harshman, Kokomo	Oct. 1975
13—John S. Farquhar, Jr. Fort Wayne	Oct. 1976
13—G. Beach Gattman, Elkhart	Oct. 1974

## ALTERNATES

District	Term Expires
1—Bernard Rosenblatt, Evansville	1976
2—Betty Dukes, Dugger	1974
3—Thomas Neathamer, Jeffersonville	1974
4—William Blaisdell, Seymour	1976
5—William G. Bannon, Terre Haute	1976
6—Glen Ward Lee, Richmond	1975
7—John Pantzer, Indianapolis	1973
7—Donald McCallum, Indianapolis	1974
8—Jack L. Alexander, Muncie	1976
9—Max N. Hoffman, Covington	1974
10—Martin O'Neill, Valparaiso	1973
11—Lloyd L. Hill, Peru	1974
12—Walter D. Griest, Fort Wayne	1974
13—Donald S. Chamberlain, South Bend	1976

## SECTION OFFICERS 1972-73

### Section on Surgery:

Chairman—J. Robert Edwards, Auburn  
Vice-chairman—Lowell Hillis, Logansport  
Secretary—Robert Nagan, Indianapolis

### Section on Internal Medicine:

Chairman—John L. Ferry, Hammond  
Vice-chairman—Thomas W. Alley, Indianapolis  
Secretary—Chas. W. Magnuson, South Bend

### Section on Family Physicians

Chairman—James T. Anderson, Greenfield  
Vice-chairman—James R. Daggy, Richmond  
Secretary—David M. Hadley, Plainfield

### Section on Obstetrics and Gynecology:

Chairman—David E. Copher, Indianapolis  
Vice-chairman—Charles R. Thomas, Indianapolis  
Secretary—James L. Mount, Bedford

### Section on Ophthalmology and Otolaryngology:

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Vice-chairman—Wallace Dyer, Evansville  
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Chairman—Willis W. Stogsdill, Indianapolis  
Secretary—David P. Lehman, Kokomo

### Section on Public Health and Preventive Medicine:

Chairman—Robert M. Seibel, Nashville  
Vice-chairman—Robert C. Speybroeck, South Bend  
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Secretary—Richard N. French, Jr., Indianapolis

### Section on Pathology and Forensic Medicine:

Chairman—Clyde Culbertson, Indianapolis  
President-elect—Wei-Ping Loh, Gary  
Secretary—Victor Muller, Indianapolis

### Section on Pediatrics:

Chairman—George F. Parker, Indianapolis  
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### Section on College Health Physicians:

Chairman—John Miller, Bloomington  
Secretary—Wayne G. Pippenger, Muncie

## DELEGATES TO THE AMA

Terms expire December 31, 1973:

Delegates	Alternates
Jack E. Shields Brownstown	Patrick J. V. Corcoran Evansville
Lowell H. Steen Hammond	Thomas C. Tyrrell Hammond

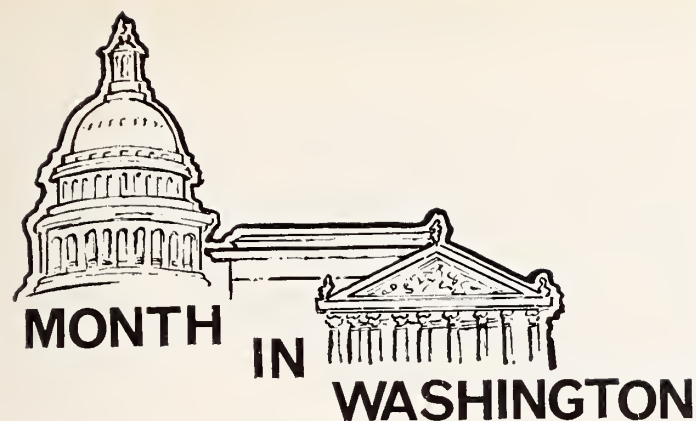
Terms expire December 31, 1974:

Delegates	Alternates
James A. Harshman Kokomo	A. Alan Fischer Indianapolis
Eugene F. Senseny Fort Wayne	Ross L. Egger Daleville
Malcolm O. Scamahorn Pittsboro	Kenneth O. Neumann Lafayette

## 1973-74 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1.	William Dye, Oakland City	Martin J. Bender, Evansville	
2.	Robert O. Bethea, Farmersburg	J. S. Brown, Carlisle	June 1974, Sullivan
3.	Claude J. Meyer, Jeffersonville	J. L. Millan, Jeffersonville	
4.	Kenneth E. Bobb, Seymour		
5.	J. Franklin Swain, Rockville	Antolin M. Montecillo, Clinton	
6.	James H. Tower, Jr., Shelbyville	Arlington M. Hudson, Connersville	
7.	Eric Clark, Plainfield	M. O. Scamahorn, Pittsboro	
8.	David Dietz, Muncie	Arthur Jay, Muncie	
9.	Milton W. Erdel, Frankfort	Harry T. Stout, Frankfort	June 13, 1974, Frankfort
10.	Mario D. Mansueto, Munster	James R. Brown, Valparaiso	
11.	Joseph S. Bean, Logansport	Fred Poehler, La Fontaine	
12.	Franklin A. Bryan, Fort Wayne	Karl R. Schladenran, Fort Wayne	
13.	Jack Hannah, Elkhart	David L. Spalding, Mishawaka	Sept. 11, 1974, Elkhart





This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to The Journal on the first of each month preceding month of issue.

William I. Bauer, M.D., has resigned as director of the controversy-ridden Professional Standards Review Organization (PSRO) program, expressing dissatisfaction with the PSRO organization setup.

The surprise step-down was a shock to the top officials at HEW who have been reeling from the loss of other high officials upset over the lengthy reorganization of the health activities at the HEW department.

Charles Edwards, M.D., Assistant HEW Secretary for Health interrupted a planned business retreat to hurry back to Washington when news of the resignation filtered out. He called a news conference but then cancelled it after the reporters had shown up. Dr. Edwards was in conference with HEW Undersecretary Frank Carlucci at that time.

The PSRO program is a particularly sensitive one to be subject to the inevitable repercussions and criticisms that follow a resignation. Members of the Senate Finance Committee have been taking a hard line on involvement of state medical societies in the PSRO review of institutional care under Medicare and Medicaid. Some physicians groups and state societies, and the PSRO advisory committee, have urged a broader authority for state societies. In general, HEW and Dr. Bauer had appeared to be attempting a middle course.

Furthermore, the gearing-up for the intricate and complicated program has been a mammoth task for Dr. Bauer.

The 48-year-old Dr. Bauer was named to the PSRO post last March after a career as a practicing internist in Greeley, Colo. Other HEW officials who have resigned in the past several months are Gordon McLeod, M.D., director of the Health Maintenance Organization (HMO) program, and Arthur Lesser, M.D., head of Maternal and Child Health Services.

In a statement, Dr. Bauer said the administration has made a "significant commitment to PSRO but that commitment has not been translated into action . . . ."

"This extremely complex program with ramifications at all levels of medical care has been provided

with limited resources and those that were made available could not be effectively administered and utilized because of the organizational structure," Dr. Bauer said.

According to an HEW spokesman, the resignation stemmed from a dispute between Drs. Bauer and Edwards over organizational control of the PSRO program. Dr. Bauer was said to believe that he could not exert meaningful authority under the present setup in which much of the field work for PSRO, involving hundreds of physicians, would not come under his line control but under the Bureau of Quality Assurance. Dr. Edwards, the spokesman said, contended that Dr. Bauer would still have the say-so, but Dr. Bauer obviously disagreed.

Underlying the dispute, apparently, has been the effort of Dr. Edwards to pry PSRO control away from Social Security and Social and Rehabilitation Services, present overseers of Medicare and Medicaid, and to give the Health Department clear jurisdiction in PSRO.

Under the reorganization, 50 physicians at Social Security and 150 in the Health Services Administration are assigned to PSRO but not directly under Dr. Bauer, who had 36 staff positions.

There was no indication from Dr. Bauer of any philosophical differences with the administration over how PSRO would function at the local and state level.

### **House Votes \$240 Million for Experimental HMOs**

The House has approved legislation that will provide federal funds to start a limited number of experimental Health Maintenance Organizations over a five-year period to the tune of \$240 million. The Senate's version of HMOs, passed months ago, would provide \$805 million over the same period. House and Senate conferees must now resolve the differences.

The compromise bill voted by the House calls for spending \$60 million this fiscal year, the Administration figure. The bill meets many objections raised to

**Continued**



# COUNTY MEDICAL SOCIETY DIRECTORY

County	President	Secretary
Adams Allen (Fort Wayne)	Norman E. Beaver, Berne Richard B. Juergens, Fort Wayne	Robert L. Boze, 265 W. Water St., Berne 46711 Herbert K. Acker, 3610 Brooklyn Ave. 46807 Mr. Larry L. Pickering, Exec. Secy., 212 Med. Ctr. Bldg., Fort Wayne Robert G. Reed, Jr., 2400 17th St., Columbus 47201 D. L. McKinney, Box 398, Otterbein Gerald Fisher, 324 W. North St., Lebanon 46052 Robert Seese, 101 W. North St., Delphi Joseph S. Bean, 1101 Michigan Ave., Logansport 46947 Thomas A. Neothomer, Medical Arts Bldg., Jeffersonville 47130 E. L. Conrad, 1207 E. Natlonol Ave., Brazil Harry T. Stout, 1201 Oak St., Frankfort 46041 Hamlin B. Lindsay, 511 E. Main St., Washington Leslie M. Baker, 501 Fourth St., Aurora Alfredo Paje, Murphy Bldg., Greensburg Harland V. Hippensteel, 208 W. 7th St., Auburn 46706 David J. Dietz, 2810 Ethel St., Muncie 47304 Daniel C. Drew, M.D., Jasper Medical Arts Bldg., Jasper 47546 Page E. Spray, 320 W. High St., Elkhart Abou Mazda, 707 W. Third St., Connersville 47331 Daniel H. Cannon, 1201 E. Spring St., New Albany Theodore Person, 601 N. Mill St., Veedersburg Joseph D. Richardson, 121 West 8th St., Rochester 46975 Don E. Pruitt, 401 W. Spruce St., Princeton 47570 E. S. Rifner, Van Buren Harry Rotman, Jasenville Joe R. Lloyd, 107 John St., Noblesville 46060 Harry T. Hensley, 11929 E. 65th St., Oaklanaon 46236
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Domingo, Greensburg William Hathaway, Auburn Carlson R. Speck, Muncie Alfred B. Scales, Huntingburg G. Beach Gattman M.D., Elkhart A. E. Angeles, Connersville Clyde Shelton, New Albany Lowell R. Stephens, Covington F. Richard Walton, Rochester William R. Wells, Princeton Henry Fisher, Marion Robert Moses, Worthington R. Adrian Lanning, Noblesville John E. Moenning, Greenfield  Wilfred J. Brockman, Corydon Eric Clark, Plainfield Phyllis Grant, New Castle Emerson C. Harvey, Burlington Richard W. Wagner, Huntington John C. Linson, Seymour Ernest R. Beaver, Rensselaer George A. Donnally, Geneva Warren R. Rucker, Madison Robert W. Ogle, Greenwood Jack L. Shanklin, Vincennes Thomas F. Keough, Warsaw F. X. Colligan, Topeka Daniel T. Ramker, Hammond  John W. Luce, Michigan City  John E. Pless, Bedford Jack D. Whitaker, Anderson Charles R. Thomas, Indianapolis  Jose R. DeJesus, Jr., Plymouth Maurice Sixbey, Denver Paul E. Ludwig, Crawfordsville William H. 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the original measure by the Administration and the American Medical Association.

Though no specific number limitation was set in the House bill, the limit of authorizations to \$240 million will provide an effective ceiling on the number of HMOs which could be established. The House Commerce Committee estimated the legislation would be used to bring to the operating stage approximately 100 new HMOs.

The bill has a flat five-year cut-off for the HMO program.

Unlike the Senate bill, the House legislation does not preempt state laws that restrict formation of HMOs. The reason given by the House Commerce Committee was "the rapid change already underway in state legislation designed to remove these barriers." Approximately 20 states have already adopted legislation specifically authorizing HMOs.

The bill limits grants or contracts for planning and initial development costs by prohibiting this assistance after 1976.

Initial development assistance would be prohibited after 1977.

Loans and loan guarantees for initial operation costs are authorized, except that loan guarantees could be provided only if the HMO will serve residents of a medically underserved area.

The bill has no authority for loan guarantees for construction projects.

For grants and contracts for feasibility studies, initial planning and initial development costs, the bill would authorize \$40 million for fiscal year 1974, \$45 million for fiscal year 1975, and \$50 million for fiscal year 1976. In addition, it would authorize \$55 million for fiscal year 1977 for grants and contracts for initial development costs. The bill would authorize \$20 million for fiscal year 1974 and \$30 million for fiscal year 1975 to be appropriated to the loan fund.

The bill, unlike the original subcommittee bill, has no authority for demonstration grants and contracts for enrollment of the indigent, for providing service in rural medically underserved areas, and for enrollment of high risk individuals. There also is no authority for special project grants and contracts, for grants for HMO management training, and for program evaluation.

Provisions for protection against insolvency of HMOs, against the cost of providing unusual amounts of health services or of providing out-of-area health services, and protection against unusual losses were not contained in the final bill. Also deleted were provisions which authorized technical assistance and con-

sultative services to aid in the planning or development of an HMO.

### Quote . . . Unquote

Below is an interesting quote found in *Presidential Documents*:

Richard Nixon, 1973, Vol. 9, #36, page 1063 and 1064.

THE PRESIDENT: "One of our major problems, incidentally, I might say, is, as you were just talking about the Trade Bill, Wilbur Mills' incapacity. I don't know whether you know he has just had an operation, a disc operation, which, incidentally, if he had asked me, I would have told him never to have it. I haven't had one but I have never known one that was successful."

### Some Dissent as to Value of National Center for Health Education

A public-private National Center for Health Education to oversee efforts to provide better health information to the public was recommended by President Nixon's Special Committee on Health Education.

In a report to the chief executive, the 17-member advisory group said future improvements in health care delivery and financing "will be virtually nullified unless there is, at the same time, an improvement in health education, which means not just supplying information about health to people, but motivating them to accept the information and put it to work in their daily lives."

Only a small fraction of the nation's health dollar is spent on public education, the report said, declaring there is a vital need for innovation and experimentation with new kinds of educational programs.

The National Center for Health Education would be a private, nonprofit organization authorized by Congress and financed from U.S. and private funds at an estimated yearly cost of about \$3 million. The Center would be managed by a 25-member board of directors appointed by the President and confirmed by the Senate. It would conduct research, coordinate state and local and national public education programs, and serve as an information clearing house.

Chairman of the advisory committee, which spent two years on the report, is R. Heath Larry, vice chairman of U.S. Steel. There were two outright dissents on the report's findings and eight additional views which included expressions of reservation about the report.

Continued



# ISMA Committees and Commissions for 1973-1974

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In addition to the National Center, the President's Committee recommended:

—An HEW office serve as focal point for government-wide health education efforts.

—Consumers be more adequately informed about the health value of products and services.

—Hospitals provide patient education programs.

—Model state health education laws.

—Business, labor be encouraged to undertake comprehensive health education programs.

—Community health education centers be established.

—Serious consideration be given to preparing selected non-professional health educators as "paramedics, in effect, in the field of health education."

Joseph Beirne, president of the Communications Workers (AFL-CIO), said the proposed center wouldn't work and that a firm commitment to the goals of health education is needed from four groups that would be the key to success: American Medical Association, American Hospital Association, American Public Health Association, and American Dental Association.

The other dissenter was Joy Cauffman, Ph.D., University of Southern California School of Medicine, who said the report discriminates against the coalition of national health organizations.

J. Henry Smith, president of the Equitable Life Assurance Society, said he was "uneasy" about the report's lack of clarification on how the Center would be set up and the "somewhat cursory" recommendations in other areas. Charles A. Stegfried, vice chairman of Metropolitan Life Insurance Company, said "numerous recommendations are made for extensive new activities without any clear indication of just what they might accomplish, what they would likely cost, or whether the hoped-for improvements would be commensurate with the cost."

### **House Fails to Override President's Veto**

President Nixon has won a showdown with Congress on health spending. The House failed to override his veto of the emergency medical services bill, making the veto stand and bolstering the administration's hopes of curbing federal spending this year.

The Senate voted before the August recess to overturn the veto.

In the interval, pro-Administration and anti-Administration forces and supporters of the bill worked hard to line up House votes for their sides in what was regarded as an important test of the President's powers.

The bill authorized \$185 million over three years to aid state and local governments set up emergency medical services to cope with auto crashes and the like. In his veto message, President Nixon said the measure would establish "a larger new federal program in an area which is traditionally a concern of state and local governments."

The chief executive also criticized a rider to the bill ordering the continued operation of eight public health service hospitals. He said "their inpatient facilities have now outlived their usefulness to the federal government."

Despite the Administration's opposition, the bill sailed through Congress by overwhelming votes.

The House vote on the veto was viewed as a key battle in the legislative war pitting congressional Democrats against the Administration, a fight not only involving the issue of economy in government but the powers of Congress and the powers of the executive branch.

President Nixon had been successful in four previous vetoes this year.

### **UAW Contract Calls for Chrysler to Pay in Full for Any NHD Program**

Labor's leading proponent of a sweeping National Health Insurance bill, Leonard Woodcock of the United Autoworkers, engineered a tentative agreement with the Chrysler corporation requiring the company to pay the full workers' tab for any National Health Insurance plan that comes down the pike.

It was believed to be the first such provision in a major labor settlement and made clear labor leaders' desire to have management shoulder the full cost of NHI. The agreement made dollars and sense from the standpoint of the UAW, but took some of the gloss off the repeated Woodcock assertions before congressional committees that workers are willing to pay their fair share of any national health program.

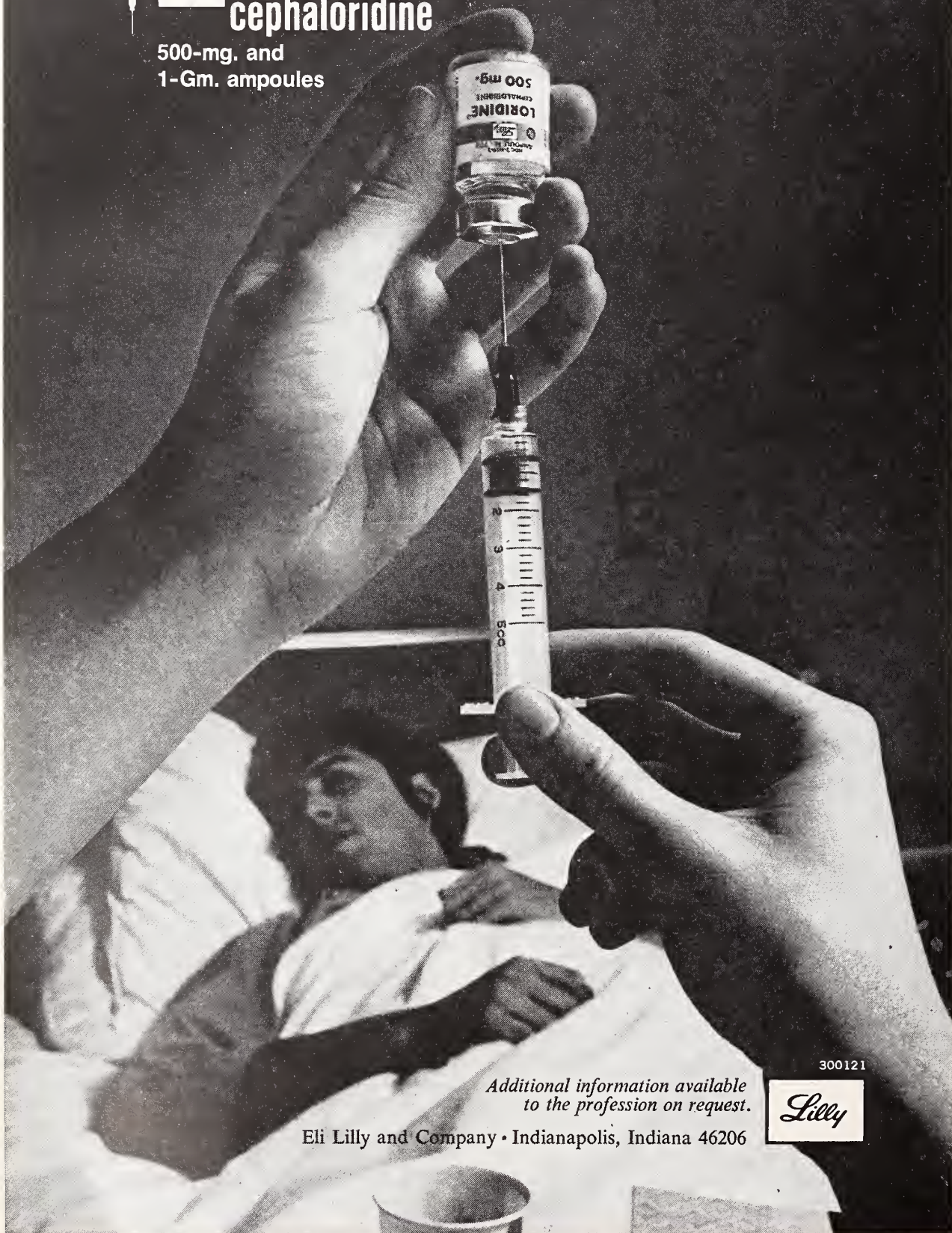
Steven Schlossberg, UAW's general counsel, was quoted as saying that autoworkers have always supported NHI but "now they have even more incentive to press for its passage since, because of the new contract, there is no economic incentive for them to be against it."

The agreement states that in the event a National Health Insurance program is enacted Chrysler will be required to pay any direct premium or taxes which may be levied on workers. ◀



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## *Advances in Radiotherapy—Improved Results Following Treatment with High Energy Electrons and 25 MEV X-Ray*

### Part One

JAMES C. KATTERJOHN, M.D.  
Indianapolis

THE primary purpose of this paper is to document improvements in radiation therapy during the past 25 years, particularly in the Central Indiana area. The second purpose is to describe the Betatron which has been fully operational for the past six years at St. Francis Hospital. The third purpose is to clarify the many advantages of the Betatron in certain clinical situations. The fourth purpose is to suggest those

areas in which additional and further improvement in radiation therapy can be expected.

The author's interest in oncology dates from January 1945 while a resident at Memorial Cancer Center in New York City. During these 29 years, great progress has been made in medicine in general, oncology particularly, and especially in radiotherapeutic oncology. The part-time radiotherapist of 1945, usually dividing his time between diagnosis and therapy and utilizing orthovoltage equipment, was frustrated in his attempt to obtain a satisfactory tumor dose and, too often, did not

achieve a rewarding survival rate. The side effects of treatment in this era were significant. Usually, the prescribed treatment dose could not be given without serious complicating skin reactions and constitutional reactions of nausea and vomiting. The choice was between accepting the complications or giving less than cancerocidal dose.

During the early 1950s supervoltage equipment came into more general use and, by 1960, most institutions doing a significant amount of radiation therapy had equipment in the one to two million electron volts (MEV) energy

Dr. Katterjohn is co-chairman of the Department of Radiology, St. Francis Hospital Center, and associate professor of Radiation Therapy, Indiana University School of Medicine, Indianapolis.



range. Cobalt 60 teletherapy, equivalent to three million volt x-ray, became a common popular choice. There was general improvement in patient tolerance of treatment with these new modalities. Larger doses could be given and improved survival rates were achieved, undoubtedly the result of an increased dose.

In the Indianapolis area, the St. Francis Hospital Cobalt Teletherapy Unit was the first in the state of Indiana and was installed in 1957. This was followed within the next three years by a Cobalt 60 Unit at Indianapolis Methodist Hospital and another at Indiana University Medical Center. St Vincent Hospital installed a Cobalt 60 Unit in 1962. Subsequently, in December 1964, Community Hospital of Indianapolis installed a 2 MEV X-ray Therapy Unit. A Cobalt Teletherapy Unit was installed in Evansville in 1958.

### **Tolerance, Survival Improved**

These supervoltage units made it possible to give larger doses of irradiation with fewer side effects than with conventional orthovoltage therapy and more people could be treated with improved tolerance and survival. The Cobalt 60 Teletherapy Units were capable of producing doses to deep tumors in the 5,000-6,000 Rad range without significant skin change. The skin-sparing effect of cobalt treatment was exceptionally good, and, for the first time in our experience, we could administer the prescribed dosage in a prolonged series of treatments to certain patients—e.g., those with seminoma and those with lymphoma. Side effects did occur, but they were less severe than with orthovoltage and there was a definite improvement in the tumor dose/volume dose ratio.

With the Cobalt Therapy Unit, skin dose was hardly considered in treating patients. It was three years

after our treatment program commenced that we began to read reports of delayed subcutaneous fibrosis in patients receiving large doses of supervoltage irradiation. These reactions were noted by us in obese patients who were unable to lie on their abdomen during treatment and the full course of therapy was given through only an anterior portal. These were painful complications usually appearing six months to one year after treatment. In most instances, the areas of fibrosis were too large to be excised. The lack of an erythematous signature in cobalt therapy was then realized to be a potential problem rather than a total blessing. In the early part of 1960, we recognized that energies higher than Cobalt 60 were needed for many patients, and we began to evaluate (for purchase) equipment in use in other major radiotherapy centers.

Early in the 1960s, linear accelerators of 4 to 6 MEV appeared in cancer centers in the United States, having been in use in England and in Scotland for several years. Betatrons up to 35 MEV began to appear in other U.S. cancer centers; these machines had been used widely in Continental Europe, particularly in Switzerland, France and Germany.

Dr. Robert Stone, eminent radiologist, was interested in the new ultravoltage machines that were appearing throughout our country and evaluated equipment in the 60 MEV range. We then began to hear of Synchrotrons of 200 MEV energies and above; but it was Dr. Stone who advised that machines in and beyond the range of 40 MEV had disadvantages other than their prohibitive cost.

Exit doses in even the largest human subjects were the limiting factors of the extremely high energies. Another troublesome feature was the induced transient radioactivity in patients following treatment

with energies above 40 MEV. Most therapists now agree that the practical and useful range of photons in human subjects is 18 to 35 MEV, and a quick perusal of depth dose charts will convince the reader of the soundness of this observation, even in cases where the high cost of the higher voltage installations might not be a consideration. Therapy with high energy neutrons and pi-mesons is currently being evaluated in this country, but reports from the use of these modalities will not be forthcoming for many years. Proton therapy has been used in Russia.

We visited and examined in detail several radiotherapy installations, including the University of Chicago, University of Maryland, Memorial Hospital in New York City, and the M.D. Anderson Hospital in Houston, Texas. A 35 MEV Braun Boveri Betatron had been installed at the University of Maryland Hospital and we made many visits during and after the installation to examine the potential value of the machine. A visit to M.D. Anderson Hospital permitted us to observe two Betatrons in use in the same institution: the 18 MEV rotational Siemens unit and the 25 MEV Allis-Chalmers unit. Our ultimate choice was the Allis-Chalmers unit which is designed after the pattern of the radiographic unit used in filming protective plates for the AEC during the development of the atomic bomb. In 1965 we ordered a 25 MEV Allis-Chalmers Betatron with electron capabilities.

### **15-Year Delay**

In 1948 there appeared a report concerning the adaptation of the Betatron for electron therapy.<sup>19</sup> At the time the report was made, a great deal of enthusiasm was expressed but more than 15 years elapsed before therapy of this type was done in this country to any significant degree. On May 1, 1963,



electron beam therapy was started in the Department of Radiotherapy<sup>22</sup> at the M.D. Anderson Hospital in Houston.

In September 1964 a meeting was held in Montreux, Switzerland, entitled "Symposium on High-Energy Electrons"<sup>7</sup> and a number of papers were presented extolling the virtues of electron beam therapy of 6 to 35 MEV energy ranges in certain clinical situations. The clinical applications were better clarified in a symposium<sup>3,6</sup> on this subject held in San Francisco in 1966. Many of the faculty of the Switzerland symposium appeared on the program at the San Francisco meeting. A similar symposium<sup>25</sup> with many of these same guests was held at the 48th Annual Meeting of the American Radium Society in Phoenix in 1966. From these meetings the many advantages and uses of electron beam were well defined.

Electron beam therapy with the Betatron consists in the use of the electron particles coming from the Betatron directly in the treatment of the patient. X-ray therapy with the Betatron consists in the use of the photons produced by allowing the electron particles to bombard a target. The chief difference, physically, is that electrons have mass and charge, and are stopped abruptly in human tissue more superficially, whereas photons are energy waves with no mass and they penetrate more deeply before they are stopped in the tissues. The electrons are actually ionizing particles as they enter the tissues, whereas in the case of photons, the ionization is produced by the photons after tissue cells are irradiated. Because of the lesser penetration of the electrons, their use is limited to the more accessible cancers and they are not used in a cancer situated in the middle of the body. The value of electrons lies in the protection of underlying tissues and in a definite response in some tumors heretofore

considered radiation-resistant.

There is observed a fundamental difference in the biological effect of electrons on some cancers contrasted with the effect of photons,<sup>24,25</sup>. This has been well documented by the observations of our European colleagues and has been confirmed in radiotherapy departments throughout our own country. We have seen the difference in our own patients. Adenocarcinomas of the bowel, breast and skin are responsive to electron therapy. Salivary gland cancers and fibrosarcomas are also responsive.

Concurrent with improvement in equipment since 1945 there has been an increase in our knowledge of tumor behavior and an improvement in treatment techniques and dosimetry. In 1945, one of the leading midwestern clinics treated lymphomas, including Hodgkin's disease, by administering a single dose of 500 Rad to each peripheral node-bearing area, then dismissing the patient to follow-up for six months before a second course of

treatment was considered. At Memorial Hospital in New York, the recommended dose in 1945 was 3,000-3,500 Rad. In the last 10 years, it has been found that this extremely sensitive tumor of Hodgkin's disease must be treated to a dose of 4,000 Rad to all node-bearing areas<sup>9,10</sup> and with this technique an overall cure rate of 70% (90% in Stage I lesions) is now achieved. This is but one example of the many types of tumors that respond to and are cured by improved radiation therapy techniques and increased dosage.

The National Cancer Institute now serves as a clearing house for institutions using different protocols for treatment. A large series of patients are now being treated by slightly different techniques and results compared. Each national meeting brings forth suggestions for improved techniques, all of which will improve survival and/or quality of survival in different types of lesions. Dosimetry is now well established for various tumors and, for those institutions where a dosimetrist is not available, computer dosimetry

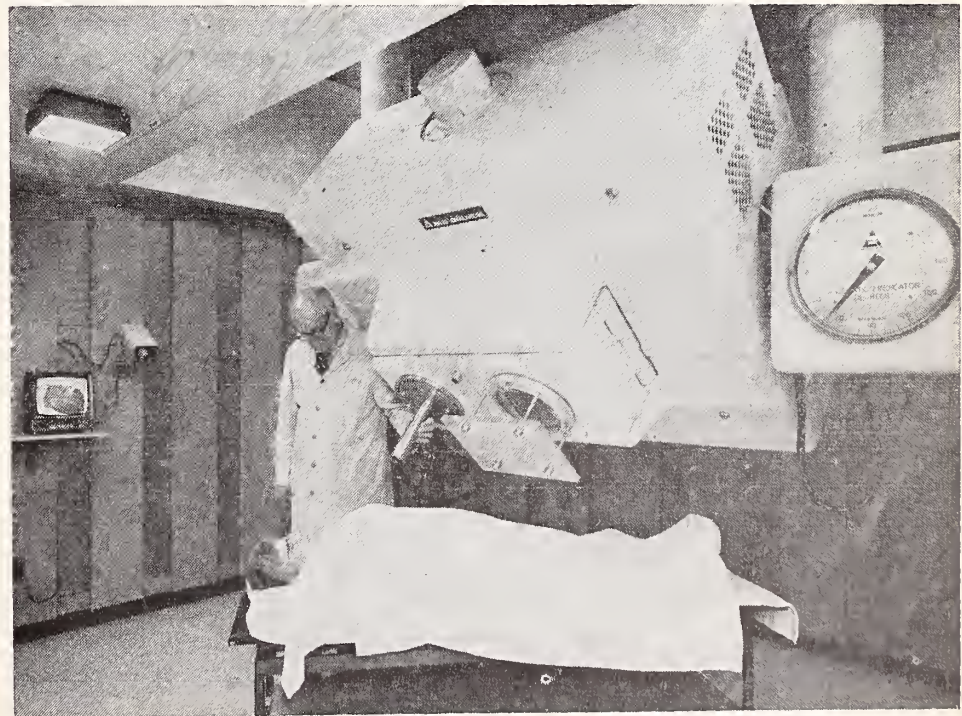


Figure 1

Betatron partially angulated. Electron beam portal to left with interchangeable cones. X-ray portal on right with polystyrene tray for blocking materials. T.V. monitor extreme left, set-up also monitored at control panel and remotely in physician's office.



can be obtained from large central treatment centers, such as the one at Memorial Hospital in New York City. This dosimetry can be obtained for individual patients at a nominal cost.

One other significant improvement in therapy in recent years is the introduction of the concept of Nominal Single Dose (NSD). In 1969, Frank Ellis<sup>8</sup> presented, in the American literature, the concept of reducing all treatment dosage to the Nominal Single Dose, a hypothesis for comparing different techniques of fractionation, rest periods and elapsed treatment time. Since there were so many different techniques utilized throughout the world, comparison of results had been virtually impossible in the past when Rad and time concepts alone were used. The NSD concept seems to work for those who use it, and currently almost all therapy departments are reporting their end result and their treatment techniques in NSD in RETS as well as Rads-Time. By utilizing the NSD concept, we can compare end results from all institutions in the world, and we now know the NSD required to sterilize a given type of tumor, and we know that an NSD that is too high is apt to produce a complication of a serious nature—such as a spinal cord injury or laryngeal cartilage necrosis.

In summary, we know exactly how far we can go in the treatment of each type of tumor and we can establish an intelligent dosage standard without worry from undesirable complications. We also know that an adequate tumor dose can be delivered with modern equipment. A final word should be said regarding the value of the multidisciplinary attack on cancer. Most radiation oncologists have available for consultation surgical oncologists and medical oncologists (mostly chemotherapists), and the three approaches to treatment problems

complement each other and greater tumor control is achieved. In many heretofore incurable tumors, significant arrests and even cures are being reported when the multidisciplinary approach is used: for example, Ewing's Tumor and osteogenic sarcoma of bone—chemotherapy and heavier radiation therapy; leukemia in children—arrested primarily through the use of chemotherapy; Wilm's tumor—radiation, surgery and chemotherapy.

In 1973, the American Board of Radiology included for membership representatives of the American Society of Therapeutic Radiology, all of whose members limit their practice exclusively to radiation therapy. This act established the place of the radiation therapist in the treatment of cancer.

### The Betatron

The Betatron was developed by Donald W. Kerst<sup>13</sup> primarily for high voltage x-ray diagnosis in industry. The Betatron is a device for accelerating electrons in a circular tube or "donut" by a 100 h.p. synchronous three-phase 440-volt motor generator which converts the incoming current to 180 CPS—4200-volt current which alternately activates two large electromagnets. The "donut" is situated between the magnets which, in turn, accelerate electrons in the "donut" to the speed of light. These electrons are accelerated about 70 volts per cycle, making about 300,000 cycles in the "donut" reach an energy of 20 MEV (million electron volts). If the flow is in one direction, the electrons bombard a target and photons are produced. If the current is reversed, the electrons are focused into a beam by a magnetic shunt and emerge as a well-focused beam of electron particles for direct treatment. The remainder of the device consists of electronic circuits and capacitors placed in an adjacent room,

and a separate operator's room with a control panel. While a detailed discussion of the problems of installation and operation are not appropriate in a clinical paper, a few sidelights may be of interest.

If the high-energy treatment room is not below ground level, with earth barriers around it, there must be at least seven feet of heavy concrete in one of the walls as a barrier for the primary beam when the machine is operating in a horizontal position. The ceiling and other walls of at least three feet of heavy concrete are needed for secondary irradiations. In some installations, such as at St. Francis Hospital, an additional small wall was constructed near the entrance corridor for the elimination of the small quantity of neutrons that were produced. Remote monitoring by television is necessary, and a wide-angle lens as well as a close-up lens is used. A separate high energy electrical service had to be installed. The carefully designed 15 tons of airconditioning were only half the amount needed, as we learned after the unit had been operating for about nine months. The heat production is considerable after prolonged use.

### Measurements and Dosimetry

When one deals with a therapy device of high energy output in the ultravoltage range, precise dosimetry is a must. A slight variation in time, distance and internal seating of the x-ray tube can alter the output and physical characteristics of the beam greatly. It is desirable to have the services of a radiation physicist and more than one system of measuring devices to insure complete accuracy. It is necessary to calibrate the x-ray output and the electron beam output at several energy levels at the beginning of each treatment day. It may be necessary to calibrate the output again at certain intervals during the day, par-



ticularly if the machine is rotated from the vertical to horizontal.

Four different external calibration systems are used. They are ionization chambers, film densitometry, thermoluminescent dosimetry and ferrous sulphate dosimetry. The latter is available from the National Bureau of Standards and is used twice a year. The most useful device and the one used daily in our department is the ionization chamber with the high energy probe inserted in a tissue-equivalent phantom of polystyrene.

X-ray film dosimetry is an important calibration device. Unexposed film is inserted in the path of the beam in a tissue-equivalent phantom, a measured exposure is made and the film is then developed and studied with a densitometer and/or an isodose plotter. Each beam is studied in profile and at right angles to the beam—the latter is used for evaluation of homogeneity of the field. Isodose lines are determined and plotted for all energies used. The isodose curves compare favorably to the average data supplied by the International Atomic Energy Agency of Vienna.<sup>5</sup>

The third system used is the thermoluminescent dosimetry system, commonly referred to as T.L.D. Lithium fluoride has an atomic nucleus that is rendered unstable or excited by exposure to x-ray. After irradiation, when the crystals are heated to a predetermined temperature, energy is released in the form of light, which in turn can be measured in Rad. Irradiation administered to the crystals bears a constant relationship to the amount of light released. Small lithium fluoride crystals measuring .5 x 5 mm are placed in phantoms of tissue-equivalent material, exposed to x-ray, then heated, and the light emission from each is measured. Isodose curves can be made from these data as well.

We regularly check our other determinations by ferrous sulphate. A given amount of ferrous sulphate is exposed to irradiation at different energy levels. The material furnished by the National Bureau of Standards is irradiated and returned to the N.B.S., where it is measured and compared to exposures from other installations. This is done twice yearly.

There is, of course, an internal ionization chamber as part of the Betatron that controls exposures given to each patient. A radium constancy pot is necessary for calibration of our high energy probe to assure a standard evaluation. A radiation physicist is employed full time and a consultant physicist visits each month to compare the findings at St. Francis with those of his parent institution, where a Betatron has been in operation for several years. Also available is an electronics engineer who can service the Betatron on the spot. In the first 12 months of operation, there was only one down day, at which time it was necessary to secure a new capacitor. All minor tube replacements, cleaning of the electron tube, seating of the electron tube, are performed by the electronics engineer, who is a full time employee.

Another device of great help has been the Rando-Alderson Phantom, where ionization chambers are irradiated and doses at various levels in the body correlated.

**Clinical Application**

Clinical situations where Betatron is indicated and where definite advantage can be realized:

(a) Electron beam for accessible lesions; (b) Higher energy x-rays for deep seated tumors.

(a) Electron beam.

- (1) External surface lesions such as skin cancer, salivary gland tumors, other adenocarcinomas presenting externally
- (2) Carcinoma penis—pri-

mary can be cured

- (3) Chest wall tumors, recurrent breast tumors and prophylactic therapy for carcinoma breast—no pulmonary fibrosis
- (4) Intra-oral treatment for oral lesions, external treatment to pharynx and mouth, opposite side of throat spared
- (5) Larynx—perfect distribution through single AP portal
- (6) Neck nodes 15-25 MEV
- (7) Metastatic cancer to bone, particularly spine
- (8) Rectum and prostate, perineal portal
- (9) Carcinoma vulva
- (10) Cerebral metastases and 1° brain tumors (rapid treatment in comatose patients)
- (11) Keloid post-excision
- (b) High energy x-rays.
  - (1) Pelvic irradiation dose to 4500 instead of 3,000 “r” well tolerated
  - (2) Treatment of lung with large anterior portal first for a short period of time to 4000 “r”, two-week rest and subsequent PA portal localizing treatment to the tumor for a tumor dose of 7000 “r”
  - (3) Extended radiotherapy for Hodgkin’s disease and other lymphomas, “mantle” technique
  - (4) Ovarian carcinoma, moving strip, also used for abdominal carcinomatosis
  - (5) Palliative therapy for bowel tumors
  - (6) Seminomas and other testicular tumors
  - (7) Bladder tumors and prostate





Figure 2

Appearance of two x-ray resistant lesions before and after electron beam therapy.

- (8) Extensive metastatic chest lesions are also treated by moving-strip
- (9) Esophagus

### Electron Beam

In the treatment of accessible cancer, there is no better modality than electron beam. Normal tissues beneath the treated area get little or no irradiation, and the ionizing particles are more efficient in destroying most tumors. In addition, there are some tumors affected by electron beam that are not sensitive to photon irradiation.<sup>6, 7, 16, 24, 25, 26</sup> One such tumor is the adenoid cystic type carcinoma, arising in the skin and subcutaneous tissues. Color photos show two lesions that did not respond to x-ray therapy but did respond to subsequent electron beam irradiation at 10 MEV. The

lip lesion (Fig. 2) occupied the entire thickness of most of the lower lip. It involved the inner mucous membrane, the intervening tissues and the skin. This patient was treated five years ago and remains well without metastases to this day.

The man (Fig. 2) with the temporal skin lesion died three years after treatment completely free of disease. Many similar surface lesions have been treated in the past six years. Other lesions usually considered radiation-resistant can be successfully treated with electron beam. These are salivary gland tumors, adenocarcinomas of the bowel or other internal organs, and connective tissue tumors such as fibrosarcoma.<sup>25</sup> Unfortunately, we did not get photographs of some of the typical bowel adenocarcinoma that were completely controlled by

electron beam. One elderly gentleman had an adenocarcinoma growing around a cecostomy that had reached a size of three inches in diameter in the year that it was allowed to grow. By placing the treatment cone over the growth, the entire tumor was irradiated consecutively with 25 MEV, 15 MEV and finally 10 MEV electrons (about one-third dose of each energy). The skin surrounding the cecostomy showed a mild erythema after completion of the treatment and the tumor was completely destroyed. The cecostomy continued to function satisfactorily. Another lady now under treatment had adenocarcinomatous nodules surrounding her colostomy. We placed a lead shield over the mucosa of the bowel and eradicated the seven nodules. Now, two years after treatment,



she has new tumors involving the mucosa of the bowel itself. We believe that they will also disappear following electron treatment. The Swiss, French and Germans have documented the responsiveness of these traditionally radiation-resistant lesions, and we have seen this improved response in the patients we have treated.

Combine the two features, increased susceptibility of tumors of glandular origin and the protection of underlying tissues, and one can appreciate the value of electrons in treating *mammary carcinoma*,<sup>3,4,6,15,17,22</sup> particularly of the chest wall. Also treated with electrons are the peripheral lymphatics of the supraclavicular space, parasternal regions and the axilla. The chest wall can be treated directly in the postoperative patient with complete irradiation from skin to parietal pleura and no irradiation will reach the lung. Hence, no delayed pulmonary fibrosis such as that seen after treatment with tangential Cobalt 60 portals.<sup>11,12</sup> In treating carcinoma of the breast, it is necessary to use a split series because the skin-sparing effect of high en-

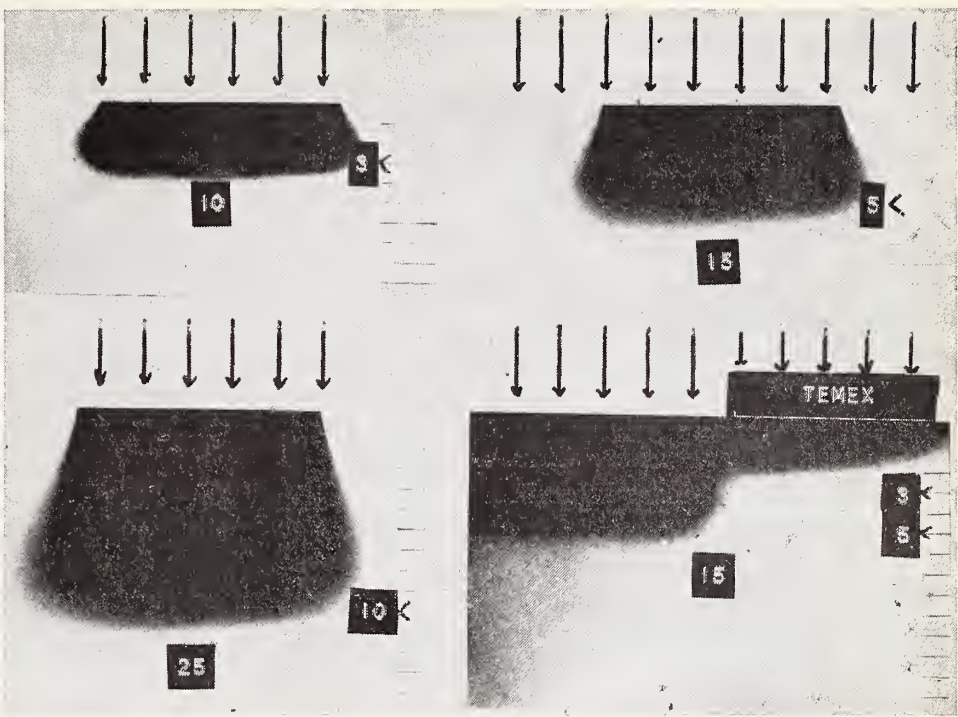


Figure 4  
Profile radiographs made in tissue equivalent phantom for electron beam at 10, 15 and 25 MEV. Also 15 MEV beam with temex over portion of field, typical dose pattern for chest wall and axilla (or parasternal) in postoperative breast patients. (Scale on right in centimeters.)

ergy photons is not a characteristic of electron beam. Reactions develop in the skin in many of the patients after about 2800 to 3000 Rads. Some will merely have pigmentation of the skin, but others will experience a brisk erythema. Some reac-

tions are delayed, and our present approach is to furlough patient after 3000 Rads for two weeks, whether or not reaction has occurred. In general, deeply pigmented individuals will merely tan, whereas individuals of fair coloring with a high degree of Celticism will react briskly to electrons. Depending upon the thickness of the chest wall, 6 to 10 MEV (Figures 3-4) electrons are used directly to a chest wall portal if there is a suspicion of residual disease. Supraclavicular, parasternal and axillary portals can be treated with 15 MEV or 25 MEV electrons, (Figures 3-4) depending upon the size of the patient and, more particularly, the thickness of overlying tissues. In some instances, we use temex rubber over the chest wall and treat either the parasternal and chest wall together, (Figure 4) or the chest wall and the axilla together in a single port. While erythema does develop, it is our impression that the final scarring resulting from therapy is much less with elec-

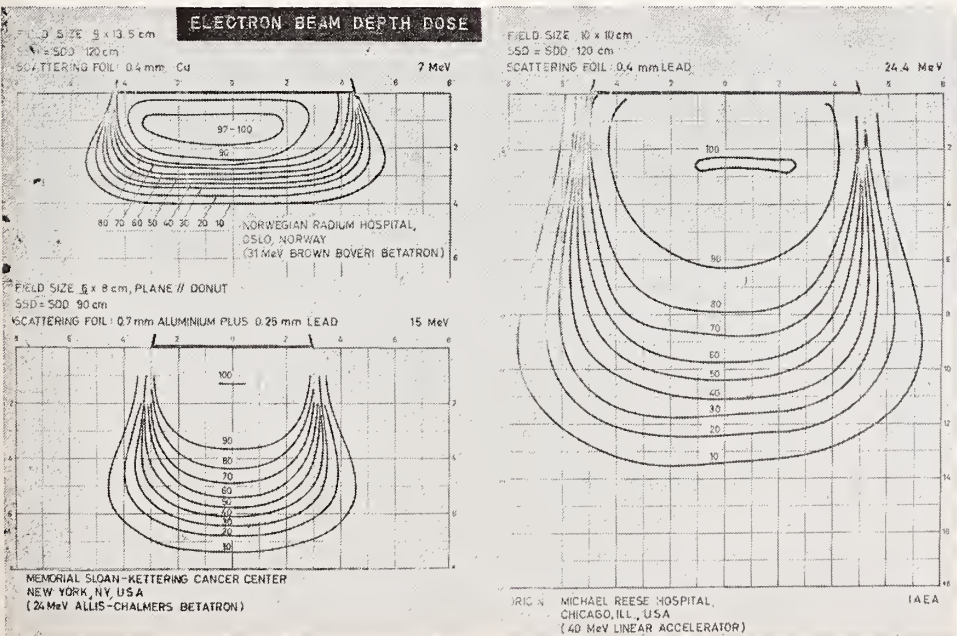


Figure 3  
Isodose charts for three most common energies used.



trons, and it is insignificant when compared to the final scarring in patients treated with supravoltage and conventional x-ray. There are several categories of patients with breast cancer who benefit from electron beam therapy:

#### A. Postoperative patients

1. Patients without clinically or pathologically involved axillary nodes where there is an inner quadrant or central lesion. These patients should have electron beam therapy to both the parasternal regions and the supraclavicular space because of the high probability of extension to these regions, particularly the parasternal area.
2. All patients with clinically or pathologically positive axillary nodes should have postoperative treatment to the peripheral lymphatics.

#### (B) Patients without major surgery

1. When supraclavicular

nodes are involved clinically, treatment should be administered after biopsy diagnosis or conservative surgery.

2. When any of the criteria of inoperability are present, the patients should receive electron beam therapy.
3. Inflammatory carcinoma is treated with electron beam without any surgical intervention.

(C) Recurrent breast carcinoma, particularly chest wall recurrences, are particularly suited to electron beam therapy and respond well. We have a number of these patients.

(D) Preoperative group. We have also had excellent results in ulcerating lesions which are quite large and bulky, making these lesions ultimately resectable.

Again, chest wall treatments can be given with electron beams without any risk of pulmonary fibrosis and this is not possible with other forms of so-called tangential therapy<sup>11,12</sup> in supervoltage range. Treatment to the postoperative tumor bed and the peripheral lymphatics, for any reason, cannot be standardized because of the clinical difference in patients coming for treatment. The patient may be six feet tall with an A cup or five feet tall with a D cup or any combination of the above. There is a great variation in clinical material in the size of the chest wall and treatment must be custom-designed.

Several patients with carcinoma of the penis have been treated quite satisfactorily when surgery is either not feasible or has been declined, and we have not experienced the same good result with Cobalt, supravoltage or orthovoltage therapy.

Another field in which electron

beam therapy is extremely useful is in certain head and neck lesions;<sup>6,7,17,20,21,22</sup> both primary lesions and metastatic lesions to the peripheral lymphatics of the neck. We have adapted to our Betatron three very small intra-oral treatment cylinders or cones of 3 cm, 2.5 cm and 2 cm in diameter. These cones can be placed directly against the intra-oral lesion, such as the tonsil, floor of the mouth or buccal mucosa, without having to pass through the skin externally. External treatment to the floor of the mouth, pharynx, posterior tongue and other oral lesions is effective when electron therapy is administered externally. Such treatments are administered with water bolus filling the oral cavity, and in this way there is no reaction to the opposite side of the throat, tongue or cheek and the patient is spared troublesome reactions to the normal side of the mouth. A unilateral sore throat is better than a bilateral sore throat.

In many instances, we have treated vocal cord carcinomas through a single AP portal given at 15 MEV electrons (Figure 5). Spinal cord dose with this technique is less than 10% of the dose administered. Again, a split series is necessary. We usually begin with a large portal including both sides of the neck and ultimately reduce the portal to a 4 to 5 cm cylinder aimed directly to the lesion itself. We now know that the dose required to eradicate the laryngeal lesion is 2000 ret (NSD). We know that lesions can be cured with 7000 Rads given in a time necessary to produce an NSD of 2000 rets.

Recurrent or primary neck nodes can be treated with electron beam. These peripheral lymphatics can be treated (1) as a primary and sole treatment of the nodes or (2) prophylactic postoperative irradiation of the neck after neck dissection, or (3) therapy to the posterior spinal

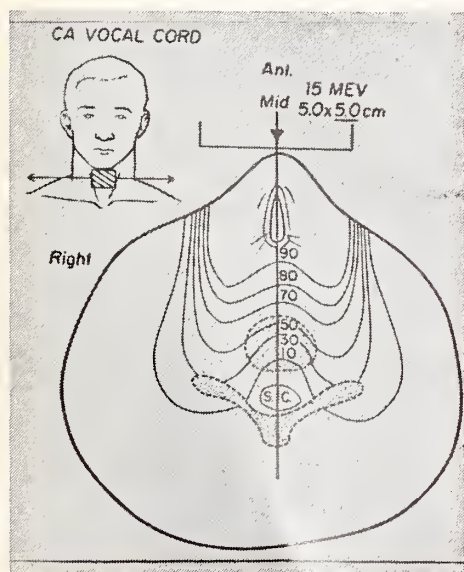


Figure 5

Isodose chart for treatment of carcinoma of the larynx. Note very small dose to spinal cord.



accessory nodes in various conditions where this portion of the neck is not explored. (4) Recurrent disease following surgery or wide-field irradiation where nodal disease recurs in a previously treated spot. (5) So-called "boost" therapy to residual tumor masses after primary treatment has been given.

Treatment after neck dissection is usually recommended<sup>21</sup> when (1) there are many positive nodes in the surgical specimen, (2) there is total replacement of the node by tumor or rupture of a cystic node, (3) tumor is found in connective tissue or tumor is found to invade the perineural lymphatics. The head and neck lesion is usually an accessible lesion and we feel that the place of electron beam therapy in treating this condition is extremely important. In many clinics, head and neck lesions make up 35 to 40% of all patients treated.

*Metastatic cancer to the bone*, particularly to the spine, is treated primarily with 25 MEV electrons up to a dose of 4000 Rads. This is accepted very well by the patient and it rarely produces more than a pigmentation in the skin of the back. If the patient does well and is more mobile, we begin treatment in two weeks with Cobalt 60 or 25 MEV x-ray and boost the total treatment to 6000 Rads. This treatment is also used if the lesion involves weight-bearing or other major bones, such as femur or humerus, particularly if fracture is impending. Rib lesions

lend themselves very well to this type of treatment.

Electron beam therapy has been widely used in treating *rectal recurrences* and *carcinoma of the prostate gland* by means of perineal portals. Usually, this is "boost" therapy after the lymphatics have been treated through anterior x-ray portals. We have one man with a carcinoma of the rectum that completely obstructed his rectum four years ago who, after treatment, has been having normal bowel movements now for more than four and a half years. For the past four years, this man has been completely comfortable; his rectal tumor would not respond to x-ray therapy but did to electron beam.

*Carcinoma of the vulva* was one of the original lesions treated by electron beam in Germany. Dr. F. Oberheuser<sup>6,18</sup> of Hamburg presented the results of treatment of carcinoma of the vulva in 1965 at the San Francisco symposium and reported 48% five-year survival with electrons contrasted with 30% survival using conventional x-ray. We have treated only five patients with carcinoma of the vulva with electron beam. Usually this disease is treated surgically in this country. We have treated several patients with metastatic vulvar carcinoma in the inguinal nodes.

Dr. Adolph Zuppinger<sup>26</sup> has reported the retreatment of *recurrent previously irradiated cancer*, utilizing electrons, in extensive lip le-

sions, breast cancers, fibrosarcomas, parotid gland tumors, thyroid tumors and breast tumors. Soft tissue sarcomas were among those lesions in which he reported good results as well as lesions of the bowel. Our experience in treating many of these so-called resistant lesions with orthovoltage and supervoltage x-rays has been disappointing but many have responded to electrons.

*Cerebral metastases and primary brain tumors* can be well treated if they are situated in the cortical portions of the brain. The advantage of utilizing electrons is our ability to treat very rapidly patients who are comatose or uncooperative. At 25 MEV, 300 Rads electrons can be administered in less than a minute. If good response is obtained after 4000 Rads, the patient can be continued on Cobalt 60 and a final dose of 6000 Rads given.

One small benign condition that has responded extremely well to electron beam therapy is the *keloid* that is treated immediately *after excision*. Ten MEV electrons are used and the response is, in our experience, superior to that we have obtained with orthovoltage x-ray. The availability of electrons to us in the past six years has expanded the scope of our therapy and it has improved our therapeutic results tremendously.

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Part Two of this article will appear in the December issue of *The Journal*. The entire list of references will be published at the end of Part Two.

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*Guest Editorials*

**The Pharmacist as a Mini-  
Doctor: Who Needs It?**

SOME pharmacy leaders are leading pharmacy right down the garden path when they say that the future of the profession lies in becoming less of a pharmacist and more of a mini-doctor. They would have professionals gain stature by relieving physicians of some of their more irksome tasks, such as taking blood pressure readings, pulse rates, and temperatures.

That so few voices have been raised against such a walleyed proposal indicates that pharmacists themselves are beginning to think a move to take over some of the duties of physicians (with or without their consent) is not too dumb. What could provide a professional with more cachet than a take-over of the duties formerly discharged by physicians?

Well, there are a few things wrong with this thinking. First, it implies that pharmacy is not a professional entity by itself, that pharmacy as pharmacy just won't do and needs to be buttressed by the addition of some of the solid professional serv-

ices provided by medicine. Second, it implies that some services that pharmacy leaders propose to take over are up for grabs because they've already been delegated to the nursing profession, and the nurses have been given these duties willingly by physicians—they haven't been strong-armed. If nurses can do it, goes the thinking, why can't pharmacists?

Well, one reason they can't is that nurses are doing their mini-doctoring in a hospital milieu under the critical eye of the biggie-doctors. Pharmacists will have to turn their pharmacies into mini-hospitals if they propose to become mini-doctors—hardly a feasible proposition.

But above all, this is the basic question: Is pharmacy a profession, and is it already doing a job?

If it is, what's all the fuss about mini-doctoring? If the pharmacist is up to his sideburns in tutoring physicians on pharmaceuticals and in advising them, is it smart to tell the physician who calls for information to hold the phone while he records a systolic and diastolic?

If pharmacy's leaders don't think pharmacists are professional, they are going to find few physicians to agree with them. The chief medi-

cal director of the Veterans Administration, Dr. Benjamin B. Wells, told the American Association of Colleges of Pharmacy at their recent convention that the physicians of the country are being overwhelmed by the mass of pharmaceutical data and they need the professional advice and services of the pharmacist today as never before. Wells doesn't think much of those who would have pharmacists abandon their profession "in pursuit of a pseudoprofessional role as a sort of auxiliary physician." Wells says the pharmacist can no longer be remote or passive in health care, and he wants him to exercise his professional abilities and be utilized to the fullest extent.

Another questioner of the mini-doctor role for pharmacists is Michael Bongiovanni, president of the U.S. Pharmaceutical Company of E. R. Squibb & Sons. At the recent Rutgers University Pharmaceutical Conference, he warned against seeking "the status of a quasi physician when there is great potential for service and fulfillment as a pharmacist." His advice is: "Seek and accept the responsibilities that come with the profession that your licenses represent. Get back to serving people, and help



your community in those areas in which your highly specialized knowledge makes you uniquely valuable. You should be discussing drug interactions, drug allergies and certainly . . . maintaining patient-profile sheets.

"There is no one better suited or more highly trained in the area of drug counseling, both to the public and to the physician. With the vast number of drug products on the market today, this has become a much-needed service." Mr. Bongiovanni, incidentally, is a graduate of the Rutgers University College of Pharmacy.

Well, here are two reasoned arguments against the mini-doctor role. And there will be more. Isn't it time for pharmacists to give the mini-doctor proposal the mini-ha-ha?—**GK—Drug Topics, July 7, 1973 Reprinted with permission.**

### From Phase Four to Phase-Out

**W**HAT will Phase IV mean to the average American? The most immediate and visible sign of the new economic regulations has been price increases for many foods. In some cases, these increases have been steep.

This is good reason to be unhappy, but it is no reason to panic.

The increases will not go on indefinitely. Prices will rise enough to cover cost increases that have been piling up during the on-again, off-again controls experiments. For foods in big demand, the price will rise further. This will increase the farmer's profit on those foods, causing him to produce more of them.

When increased supplies are available, the price rises will taper off. Some prices may even decline. *But it won't happen overnight.*

It takes months to plant and harvest crops. The availability and

price of the feed grain, in turn, influences the planning of stock breeders. Then it takes from months (chickens) to years (cattle) to raise the livestock to marketable size. So that's the minimum range of time required to get things straightened out—if we don't upset the process with a new round of controls or a new wave of budget-busting federal spending.

Why can't the government just keep the lid on all prices? Lots of politicians will be ready to suggest that it can and should. However, the latest freeze was an excellent illustration of the dangerous folly of controls.

Farmers destroyed baby chicks and sent dairy cows, laying hens and pregnant sows to the slaughterhouse because they could not sell the meat for a high enough price to pay their feed bills.

At least 43 manufacturing plants had to shut down. Many were forced to sell their products for less than the cost of making them. Many other businesses had to cut back operations and lay off employees.

These business and farm cutbacks worsened existing shortages and created new ones. The shortages will make remaining supplies more valuable, thus, more expensive to buy. And that, friends, is how economic controls actually increase inflation, rather than curing it.

All of these horrors developed after about one month of "freeze." Imagine the shape we'd be in if a freeze lasted for a year or two.

There is no easy way out. The trade-off is between shortages and price increases.

If Phase IV lasts a long time, we will have a slower rate of price increases and more shortages. If Phase IV ends quickly, we will have a quick "bulge" in prices followed by abundant supplies. That's the choice.

Anybody who tells you we can have the best of both worlds is

either economically naive or a liar.

The most sensible course is to take the bitter medicine—price increases—and get it over with. One dose will be enough, if the federal budget is kept in balance and the Federal Reserve System restrains the expansion of the money supply.

I sincerely hope that is what happens. If fiscal and monetary responsibility proves too much to ask of the Federal Government, we will be headed for an economic disaster of the first magnitude.—**Arch N. Booth, Chief Executive Officer, Chamber of Commerce of the United States, Washington, D.C.**

### May It Rest in Peace

**O**NE thing noticeable at the APhA Convention this summer in Boston was **the merciful lack of attention to the repeal of the anti-substitution laws.** This controversial subject is one that should have been laid to rest long ago. While it is too much to hope that the lack of attention at this convention is a precursor to the abandonment of this particular project on the part of the association, it would be hoped this would be true.

**The experience in the states that have attempted to circumvent the anti-substitution laws by establishing a restrictive formulary has been uniformly poor. It has not produced any great financial windfall for the patient.** The fanciful savings that were supposed to result for the patient from curtailed inventories or ability to dispense a lesser cost product, just don't come true in enough instances to make the exercise and the cost of it worthwhile.

In the second place **it does not enhance the professional prestige of the pharmacist.** As a matter of fact the laws passed and their execution to date has seemed to be **demeaning not only to the pharmacist, but the physician.** In one case the patient has been allowed to make the



decision as to what product might be dispensed on his prescription!

As we have contended since the launching of this particular project on the part of the American Pharmaceutical Association, **the competent pharmacist in the exercise of his professional skill and judgment, in his communication with patient and physician can handle this situation without resort to special legislation to permit it.** It has been done in hospitals for years and has been done in many community pharmacies for an equal number of years. Many pharmacists control their inventory in a very positive way by working with their physicians and in most instances there is some benefit to the patient. Perhaps it is not always a benefit in lower cost, but better service results in many cases.

We would hope at this point in time that the state association executives would take a close look at what is happening and put to rest any plans they have for proceeding with this particular type of legislation. **It has caused troubles everywhere it has been introduced. It involves consumers and union people in the practice of the profession.** It excites the latter to expect things that just don't happen. It has produced price posting laws which have not been beneficial to the patient in spite of his dreams to the contrary.

**Let us continue to be merciful and let this sleeping dog lie.**—*Action in Pharmacy, September 1973.*

## Legalizing Russian Roulette

A NUMBER OF STATES, now including California, have put into legislative process a law which is legalizing therapeutic "Russian roulette" in the field of medicine. It is difficult to comprehend why some vested interests and legislators cannot understand that *dead is dead*, even if the patient who dies has

done so in a substitution drug catastrophe.

Last year *Medical Tribune* reported on the mortal hazard of variations in bioavailability of cardiac glycosides. We noted that hundreds of recalls were unattended by any warning. Cardiologists are sensitive to the very narrow margin between therapeutic efficacy and deadly toxicity with cardiac glycosides. There is no margin for error. Yet hundreds of recalls were made for variations in potency—quietly—and FDA warnings were conspicuous by their absence. Unknowingly, doctors were exposing their patients to a mortal hazard when they prescribed generic glycosides. The irony of the situation was that this danger was noted before the 1938 new drug amendments. The passage of that law did nothing to correct that situation. During the Kefauver hearings, when drug toxicity was used as justification for new legislation, the side effects of the cardiac glycosides, which accounted for one out of five reported problems, were virtually "swept under the rug." And in the following 10 years practically nothing was done about it.

When *Medical Tribune* called this to the attention of an FDA official, he acknowledged that the variability in cardiac glycosides created a situation in which the use of generic glycosides of varying potency for cardiac patients could be compared to "Russian roulette."

The number of deaths in this single instance is difficult to determine, and the full scope of such a drug disaster can probably never be defined. In the face of such desperate danger, it is incomprehensible that legislators pushed by vested interests and pulled by the attraction of populism can be so irresponsible as to disregard the warnings of previous disasters and those of the A.M.A. and other highly responsible bodies of medicine.

In addition to the dangers of

toxicity and the dangers of inefficacy which the substitution drug bill can create, there are other problems, such as the loss to patients of the protection of drug liability insurance, which provides economic safeguards for them and their physicians. Certainly the legislators will not personally provide such insurance. Will their laws provide that drug liability be covered by the state? Or will it require that special drug insurance be carried by pharmacists or physicians? Or is such legislation another instance of irresponsible headline hunting which places patients in double jeopardy?

Physicians, medical organizations, and public service institutions must redouble their efforts to stop such mischief-making laws, which may bring greater profits to a few but death, disability, and economic disaster to many.—**Editorial by Arthur M. Sackler, M.D., in the *Medical Tribune*, August 22, 1973.**

## Editorial Notes . . .

The treatment of hyperkinetic children with coffee is reported to be as effective as treatment with amphetamine. Dr. Robert Schnackenberg reports good results in the *American Journal of Psychiatry*. Two cups of coffee daily is enough. The clinical study was on the triple blind principle. The children knew what they were getting but didn't know what for, the doctor knew what it was for but didn't tell the schoolteachers who acted as unbiased monitors. The children were off of all drugs for three weeks, then on coffee. The teachers rated the subjects' behavior week by week. The coffee score was slightly better than was that for other stimulants. Also cost less—\$10 per year for coffee—about \$100 per year for other drugs. The big difference was the lack of side effects for those on coffee. ◀



# A "Paramedic" Program Provided by Marion County General Hospital

ANNABELLE PAUL  
Indianapolis

INDIANAPOLIS has joined the growing number of cities across the nation in providing a "paramedic" program at Marion County General Hospital.

John G. Suelzer, M.D., director of the Ambulance Division at General, explained the new program as one which "brings emergency life-saving procedures closer to the patient."

With the use of a specially equipped "MEDIC" ambulance, the "paramedics" can begin stabilization of a victim's vital signs immediately upon arrival at the scene of the emergency.

The success of the program, which began last May at General Hospital after three years of plan-

ning, has gone beyond the expectations of its planners. During the first month of operation, the program was credited with saving the lives of 12 persons.

"The immediate results of this type of emergency treatment have been very worthwhile," commented Dr. Suelzer.

The program has been most effective in two major areas: (1) cardiac arrest and (2) severe trauma, and is part of an effort to reduce the national 50% mortality rate of heart attack victims who die before they reach the hospital.

In 450 hours of training, paramedics learn basic stabilization procedures for a cardiac arrest victim, administration and interpretation of

an EKG, cardiac defibrillation, administration of intravenous fluids, airway control and intubation.

Paramedics also gain experience while working in the hospital's emergency and operating rooms, coronary, intensive and respiratory care units, in pathology and autopsy, and the department of obstetrics and gynecology.

The paramedic program has been received most favorably by Indianapolis physicians, the Marion County Heart Association, and rescue teams of the Indianapolis Fire Department and Marion County Volunteer Firemen's Association.

Future plans for expansion include the training of more paramedics, a 24-hour operation of the MEDIC ambulance, and the addition of another MEDIC ambulance and crew by the end of the year.

But this expansion is feasible only as funding permits.

Presently, only one MEDIC unit is operated 7 a.m. to 11 p.m. daily by a crew of eight paramedics.

"Knowing the budgeting problems incurred by the Health and Hospital Corporation, it is unlikely the program will have any significant expansion without the help of outsiders," explained Dr. Suelzer.

The need for additional MEDIC units and trained paramedics cannot be stressed enough, according to Ambulance Division staff. Paramedics feel strongly that they could do much more in the way of helping people if they only had additional equipment and personnel.

One paramedic contends, "We

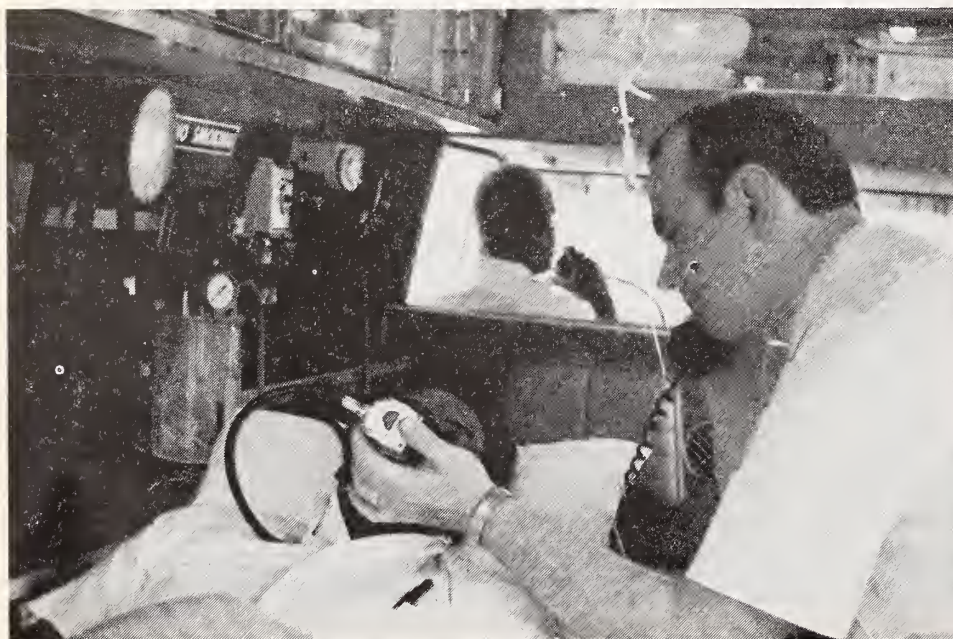


Figure 1

A simulated enroute patient-care situation shows the administration of intravenous fluids and oxygen and the use of a phone in direct contact with the emergency room.—Photo courtesy of Marion County General Hospital, Indianapolis.



need more paramedics and additional MEDIC ambulances badly. At a call last week a man was pronounced dead. My partner and I found a slight pulse, however. The man's heart was fibrillating. If we only had had the equipment the MEDIC carries, we could have probably restored a normal heart beat right on the spot. We got the man to General alive, but he probably had brain damage due to lack of oxygen."

Dr. Suelzer noted, "We have one MEDIC ambulance on call to any agency in Marion County, which covers 402 square miles. Already, quite a number of occasions have

arisen in which a critical cardiac arrest victim has not had the benefit of the MEDIC because it was on another run."

Hopefully, legislation and additional funding will allow the program to expand to the extent of meeting the needs of citizens of Indianapolis and central Indiana.

Legislation to set training requirements and equip all ambulances in the state has been proposed in three sessions, but has not yet passed the legislature.

Dr. Suelzer commented, "With the number of people maimed and killed on the highways and the high

incidence of heart attack victims in the United States (the highest cause of death in adults), it seems incredible that people are so far behind in providing rescue services for these victims—the kind that will provide immediate help, and not just transportation."

He added, "The paramedic program has already demonstrated its usefulness across the country and, with the success we've had here in Indianapolis over the past few months, I think the program has proved its value."

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# *The Woman's Auxiliary* Reports to ISMA

Since the health system we know today has come under governmental and media criticism, we must examine why the bad press; how should we react to it; and then, what can we do to counteract bad publicity.



The "horse and buggy doctor" so often romanticized as a beloved establishment of early Americana is most certainly gone—and, I would think, good riddance. Although most assuredly a lovable and colorful personality, his medical science was limited. Even though he did make that long bemoaned "house call," there wasn't a great deal he could do once he arrived. What happened to the "horse and buggy" doctor? He vanished. Because of the tremendous acceleration of medical information and technology plus a subsequent American population explosion, the emergent "Cadillac" American doctor was not only better informed but also busier and more effective than his "horse and buggy" counterpart. He could now do more for his patients. His medicine is more sophisticated and undoubtedly he is paid better for his efforts. He is, however, not only thanked less but also criticized severely. Why—if he is a more effective doctor? Is it only the money he makes that causes this criticism? Is the health care Americans receive really that bad? Or, is it that disease is no longer tolerable. Pioneer Americans accepted early death and suffering as their lot in life. Modern Americans now believe that good health is their inalienable right. The public demands their good health be provided by the medical profession immediately through any available miracle of knowledge or technology.

We obviously cannot return to a highly personalized medical care system. We cannot return because there are too many patients, with too many demands and too few doctors with too much to be learned. Nor can we easily turn around the ill effects of TV "specials," and the professionally written speeches of opportunistic politicians that convince the American populace they are being shortchanged by their health care systems. We can, however, learn to dispassionately answer critics without whining or anger. No one is interested in our rough years of residency and internship. Nor are they interested in how much more clever is our modern doctor than the average fellow. What they are interested in is their own personal good health and how health care is delivered to them individually.

Most of us in a social situation cannot discuss intelligently the state of someone's health. However, through the information provided by the AMA and the Auxiliary, we can become informed about health care delivery and the proposed changes. Rather than be angry and personally offended because there is a threat of socialized medicine, let us rather learn what the proposed alternatives to "fee-for-service" are and be able to discuss the merits and/or faults of pending legislation. The Political Action Committee is organized to inform. We must become cognizant of state and national governmental proposals.

It is certainly time Medicine answered its critics. The way to answer may not always be direct. We must function through our programs and projects, no matter what our particular personal interests, so that we can serve as catalysts, leaders and opinion makers. Political awareness is necessary for survival. There is room in a variety of organizations for every kind of individual. Personal example is invaluable and one's influence is usually in direct proportion to the respect he or she has earned. We must be involved in our communities. Our public image, of course, begins at home on our own telephone with our own associates and friends. Tact and diplomacy coupled with solid knowledge and political awareness can serve as our foundation to build a more successful public image.

**Mrs. Milton R. Carlson, Publicity Chairman**

(In order that we are able to present a broader picture of Auxiliary to the ISMA, there will be guest reporters from time to time. Mrs. Carlson has taken this opportunity to make us all aware of the public image of the physician.)

*Pat Strgsdill*



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These same characteristics make Lomotil useful in controlling the diarrhea associated with gastroenteritis, antibiotic therapy and acute infections.





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Each tablet and each 5 ml. of liquid contain:  
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(Warning: May be habit forming)  
atropine sulfate . . . . . 0.025 mg.

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**IMPORTANT INFORMATION:** This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.

**Indications:** Lomotil is effective as adjunctive therapy in the management of diarrhea.

**Contraindications:** In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

**Warnings:** Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

**Usage in pregnancy:** Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

**Precautions:** Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

**Adverse reactions:** Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

**Dosage and administration:** **Lomotil is contraindicated in children less than 2 years old.** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

**Overdosage:** Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

**Dosage forms:** *Tablets*, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid*, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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## Placidyl® (ETHCHLORVYNOL)

### Brief Summary

**Indications**—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

**Contraindications**—Drug hypersensitivity and porphyria.

**Warnings**—Not recommended during the first and second trimester of pregnancy. Caution patients of possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

**Precautions**—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitriptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

**Adverse Reactions**—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 305432



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# *The Fourth Annual Retreat*

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Fort Wayne

PATRICK J. V. CORCORAN, M.D.

Evansville

ROSS L. EGGER, M.D.

Daleville

JAMES H. GOSMAN, M.D.

Indianapolis

ON April 7-8, 1973, at the Nashville, Brown County, Ramada Inn medical students, house officers, faculty, and practicing physicians spent a weekend discussing some of their mutual problems. Like the previous three Retreats, this outing was again sponsored by the Indiana State Medical Association and Indiana University School of Medicine. A new feature this year was the inclusion of a delegation of interns and residents, the "bridge" between students and practitioners.

The first Retreat at French Lick, in 1969, was a shakedown session in which misconceptions, distrust and tensions were dispelled and the groundwork was laid for mutual understanding of shared concerns.<sup>1</sup> The second Retreat, in 1970, was devoted to a consideration of medical aspects of social problems and community action programs, and of medical school admission and curriculum concerns.<sup>2</sup> The third Retreat was somewhat more structured and action-oriented; it involved an intensive discussion of selection of medical students, relevance of the medical school curriculum, and mechanisms for interaction between faculty and the students. Recommendations emanating from that Retreat<sup>3</sup> resulted in some

modifications of policy and in new programs adopted by the School of Medicine.

The theme this year was **The Physician-Patient Interface**, a logical progression of the pattern developed in the preceding Retreats. Four topics highlighted the agenda: (1) Primary Medical Care; (2) Access to Health Care; (3) The Team Care Concept; and (4) Emerging Health Professionals. The participants were selected by the sponsoring organizations; the administration of the School of Medicine asked the department chairmen for nominees to represent the faculty; the Student Council nominated five members from each of the four classes; the Commission on Medical Education and Licensure and the Board of Trustees of the State Medical Association provided a panel of practitioners. House officers from hospitals throughout the state were invited by the Association of Indiana Directors of Medical Education. The participants were sent preliminary mailings of material to serve as a basis for some of the discussions (titles listed).<sup>4</sup>

When registering, the retreatants (Appendix B) were asked to select one of the four groups, arranged by topics, in which to partic-

ipate. Students, house officers, faculty and practitioners were fairly evenly distributed among these groups. In each group, a member of the faculty acted as moderator, a practitioner led the discussion with an introductory thematic presentation, and a student served as recorder.

The program for the Retreat is listed in the Appendix.

During the opening plenary session Dr. James H. Gosman, President of the Indiana State Medical Association, and Dr. Steven C. Beering, Associate Dean of the School of Medicine, presented introductory discourses. Dr. Gosman also separately discussed trends in the evaluation of medical practice, particularly PSRO. In the concluding plenary session on Sunday each group presented its conclusions and recommendations, and Dr. Beering and Dr. Gosman gave general summaries.

In the final session, some conclusions and recommendations were suggested, notably that the Retreat should be repeated annually, that it should be held in a relatively secluded site, that it is best to conduct it independently of other competing activities, that the time preferred for it is in the spring, and



that reports should be made to the sponsoring organizations. It was the consensus that future Retreats should include topics of socioeconomic aspects and management technology as applied to health care.

Summaries of the reports of the groups are as follows:

#### **Primary Medical Care**

**A. ALAN FISCHER, M.D.\***

Moderator

**ROSS L. EGGER, M.D.**

Discussion Leader

**GARRE BLAIR**

Recorder

This group discussed many facets of primary health care. The subject was approached in two ways: (1) questions were raised and freely discussed; (2) recommendations were suggested in regard to improving the delivery of primary health care.

Some of the basic questions that were presented with key points of discussion are as follows:

(1) What is the definition of a primary care physician? There are many different published definitions by the AMA and other groups but are these definitions valid? Some define a primary care physician as the doctor who has first contact with the patient and provides continuous and comprehensive medical care. Some define sporadic urgent medical care such as available in the emergency room setting also as one form of primary care.

(2) Is there really a deficit of primary care physicians no matter how defined? Some believe that, rather than a true shortage, there is really overuse and abuse by patients of available medical care. Many feel there is, in fact, an exceptionally severe shortage of trained family physicians. Is part of the shortage due to the fact that specialists do not receive training to prepare them to do primary care? Some suggest that pressures by the federal government are more related to demonstrate a patient need without consideration of medical care desires of the public. Concern was expressed regarding the many surveys done by the federal government and as to the accuracy of the statistics presented. Do these studies really show the need for the various types of physicians, especially primary care physicians needed in given areas. An example was made of a recent study in Detroit in which such data was supposedly accumulated but, in fact, no one surveyed was asked,

"What kind of a doctor do you really desire?" Are there really more surgeons and other specialists than needed or desired by the public?

(3) Are there too few students entering the primary care field because of lack of exposure to local M. D.s that give this type of care? Do specialists in the medical school atmosphere demonstrate the primary care aspect of patient care to the students? Assuming that there is a shortage of primary care physicians, how can such a shortage be best overcome?

The following are some of the recommendations made after the long discussion concerned with these questions:

(1) Educate the patient in how best to make use of the services of a primary care physician. Many people talk to this subject but very few do anything about it. Can a patient be so trained to know when an earache requires the attention of a physician? It seems necessary that patients be educated not to waste the primary care physician's time but instead better utilize the primary care physician in order to erase some of the medical care services shortage.

(2) Encourage students into the primary health care field by early exposure to the private practice of medicine.

(3) The number of available residency positions in Family Practice must be increased in number in the state of Indiana. Some of the suggestions to accomplish more available positions in Family Practice training were as follows: (a) Increase state and federal support. (b) Proportion the actual number and type of physicians desired by the public to the number of residency positions available. For example, should general surgical residency positions be increased or would it be better to convert the dollar spent in that training to Family Practice Programs? (c) General support to outpatient primary care facilities such as emergency room corporations, group practices, and other systems presently operational that give large scale primary care to the community. (d) The medical school faculty must emphasize the interpersonal, doctor-patient relationships if they are to serve as a model to students and residents. (e) Establish a Family Practice Model Office Unit on the medical campus and utilize the existing Family Practice Residency Programs as models for clerkship experience in primary office care. It was noted that a medical student could go through school and become an ophthalmologist or gynecologist, for instance, and never have exposure to private office practice and care

for an entire family. (f) Seminars should be established to teach how to organize and manage a private office. It was stressed that many students have no concept of how to set up an office. They do not know what to expect in the "real world" and many students are, therefore, afraid to go out into the private practice of medicine. Professionals in development and management of office practice as well as successful practicing physicians should be assembled to educate the student and resident physician in this regard and this alone might attract more students into primary health care fields.

#### **Access to Health Care**

**DR. RICHARD N. FRENCH\***

Moderator

**DR. JOHN S. FARQUHAR, JR.**

Discussion Leader

**MR. MICHAEL BUBB**

Recorder

It was first necessary to identify and categorize the needs of the consumer in order to focus on the various aspects of health care and utilization of manpower and the effect of paramedical personnel. For our purposes we define the acutely ill as those requiring emergency care or immediate crisis intervention. A non-crisis group included patients whose illnesses were not immediately life threatening, those who were only partially impaired and the "worried well." The final group was the healthy consumer who presents us with the focus on preventive or prospective health care. The needs of each member of these groups appear to be influenced by the degree of impairment, culturally based attitudes and the individual's perception of his problem.

The access to health care for the acutely ill has been dramatically improved in recent years. Facilities and transportation are generally available when considering both geographic area and socioeconomic classes. We recognize that there continue to be problems in systems of emergency care. For example, the education of first aid men, ambulance drivers and emergency room personnel must be continuously implemented and evaluated in order to maintain quality care.

In examining the non-crisis group and the healthy consumer, problems in accessibility of health care are evident. This is particularly noted in problems with continuity of care and preventive health care. All too easily we tend to focus on manpower and distribution of manpower as a solution to inadequacies



in continuity of care. There are some suggestions however that such a consideration is simplistic. For example, Russia, which now has one of the better doctor-patient ratios, continues to find its physicians doing primarily crisis care rather than adequately developing continuity of care and prospective health care. Continuity of care definition and expectations of both doctor and patient are influenced by cultural and socioeconomic factors, pressures of time, priorities of other life situations and perhaps even the focus of the physician's medical training. Although continuity of care has been recognized as a problem in lower socioeconomic groups, it still remains a problem in other socioeconomic groups as well.

Perhaps harshly stated, prospective health care still remains more an ideal than a fact. Definitions of prospective care, coordination of health care groups and education of the public have only been partially successful. Physicians who have implemented prospective care for their patients have found it necessary to reorganize their time priorities.

In the time available we chose to identify certain areas which most readily demonstrate solutions to problems of continuity of care and prospective care. Inadequacies in transmission of information by such vehicles as the hospital record and office record have been cited many times. Our group unanimously recommended implementation of the problem-oriented medical record. A careful study of the computer centered data base with safeguards for confidentiality should continue to be explored.

Recognizing the consumer has an important role in his prospective health care, emphasis should be placed on motivating the public to this charge. Scare tactics have been unsatisfactory. Some form of reward system to promote the consumer's interest should be considered. One of the more fanciful notions might be to allow a tax deduction for those individuals or families who have a routine yearly physical examination. Recognizing the costs of health care as a problem in accessibility, the group discussed the medi-credit tax incentive approach supported by the American Medical Association. The group felt that every patient should be offered the chance to contribute toward his health care, regardless of his socioeconomic level.

Paramedical personnel affect the access to health care. Whether a receptionist, lab technician or nurse, the paramedical professional must have a clear-

cut concept of his role in the health care system. The group noted that occasionally barriers to medical care occur even at the level of the receptionist and patient communicating over an appointment time. The receptionist, for example, may be confused about her job responsibility or the employer's expectations.

In regard to better utilization of manpower, we feel that the modern medical student should be taught both theory and application of prospective health care. With our emphasis on problem-solving approaches, much of medical training today focuses on crisis-oriented approaches.

### **The Team Care Concept**

Dr. JAMES E. CARTER  
Moderator  
DR. MERRITT O. ALCORN  
Discussion Leader  
MR. GREG LARKIN\*  
Recorder

The challenge accepted by our group was not only to attempt to derive an acceptable definition of the term "team care," but to then devise a method of practical application and utilization for urban and rural communities of Indiana.

After much debate the concept of the medical "team" of a community was agreed to consist of all medical and paramedical personnel and facilities functioning in a community for health care delivery. Such then would include physicians, nursing personnel and other allied health personnel available in a particular community. Natural progression then led to the discussion of what would define a "comprehensive team," that is, a team able to deliver appropriate and sufficient health care for each of the many communities of Indiana. It was generally agreed that just as size and demands of a community vary, so would the components necessary for a comprehensive team vary. The term "comprehensive team" then could be defined but the requirements could not. Instead, it was realized that such would vary with each particular health situation of a given community.

With this concept and theory generally outlined, a practical application to the medical community and the residents of Indiana was considered. It was felt, in order to derive a comprehensive team care system for each individual community, it would be necessary to assess each community for present facilities, personnel and health care demands, as well as the willingness of each community to improve or provide addi-

tional medical facilities if deemed necessary. Such a community evaluation, or "health care profile," could be done by a "task force" consisting of physicians, representatives of the State Board of Health, local community members and medical students. The inclusion of medical students was considered vital in order to allow the students to become familiar with those communities in need of physicians, as well as to allow the student to help design a comprehensive team for a community where he may then be interested in establishing a practice.

Once this task force completed its evaluation, it would report back to the "Central Assessment Committee." This committee would consist of members of ISMA, faculty of the medical and allied health schools of Indiana, representatives of the State Board of Health and several medical students. The purpose of this central committee would be that of a "clearinghouse" for the evaluations of the many task force reports. It would be the responsibility of the committee to examine the task force reports, centrally tabulate the needs, and cite the willingness and plans of each community to assist the medical society construct a comprehensive team program for the involved community. Also the committee would be continually reassessing and updating each community's progress or regress. This information would be distributed to the schools of medicine, nursing, dentistry, social work and other paramedical institutions in Indiana, as well as the entire membership of ISMA.

In a series of meetings, a discussion group with members representing nearly all aspects of the medical association verbally designed a unique program to better health care delivery in Indiana. Such a program will allow for individual tailoring to meet the needs and expectations of each individual community.

Briefly, such a program is based on a Central Assessment Committee, whose membership would be representative of the majority of the medical field. "Task forces" consisting of medical personnel and local community members would provide the central committee a "health care profile" of each community. Such a profile would cite the existing facilities, available personnel in all fields of medicine, development projections, patient needs and community characteristics.

The Assessment Committee would then make available these reports, together with its recommendations of alterations needed in order to achieve a



comprehensive team care status.

At the conclusion of the group discussion, it was unanimously felt that the merits of the concepts of "team care," "Assessment Committee" and "task forces" include a statewide effort of the communities and the Indiana State Medical Association to begin to look critically at any community upon request and evaluate and suggest procedures to better its health care system. Also, with the direct inclusion of medical students, the student body would become more aware of the particular needs in Indiana and help mold a comprehensive health care system to which they would be eager to belong.

**IN ADDENDUM:** At the presentation of this report to all the participants at the conclusion of the retreat, Dr. James H. Gosman, President of ISMA, generously offered facilities to begin a feasibility study of the above concepts. On July 8, 1973, the Subcommittee on Rural Health of ISMA, chaired by Dr. R. D. Hawkins, met to discuss the Central Assessment Committee concept, formed a subcommittee under the direction of Dr. R. Murray for the purpose of further examination of the feasibility of a Central Assessment Committee for the state of Indiana.

#### **Emerging Health Professionals**

**DR. RAYMOND H. MURRAY**

Moderator

**DR. FRANKLIN A. BRYAN\***

Discussion Leader

**MR. FRED MASHAN**

Recorder

The emerging health professional was defined as the Physician Assistant. In determining what the Physician Assistant really is, we spent much of our time talking about the Physician Assistant and the Nurse Practitioner, both of whom are considered a kind of health professional. There are three classifications of Physician Assistant: Type A, Type B and Type C. The Type we are most concerned with and interested in working with is the Assistant to the Primary Care Physician. This is the Type for which the American Medical Association has established guidelines and determined essentials of education. The Assistant to the Primary Care Physician is a Type A Physician Assistant. A Type A Assistant, in general, is a person who has been trained to do histories and physicals, to collect data, both physical and laboratory, and present it to the responsible physician in a way that he can make a determination of further diagnostic and

therapeutic procedures which should be done. This Assistant may then help the Physician in carrying out these therapeutic and diagnostic measures.

The Type B Physician Assistant is a more specialized Physician Assistant and one who is limited to a specialized field. This assistant is still able to make some independent decisions, but with a little less freedom than the Type A. This Physician Assistant would be more like an assistant who works in a Renal Dialysis Unit.

The Type C Physician Assistant has very limited training in a very small area and is not able to make independent judgments and requires very close supervision.

The general discussion and consideration in our group, then, had to do with the Type A and Type B Physician Assistants. Of these, there are two major categories—the Physician Assistant who is an extension of the Practicing Physician who is responsible for all the functions of this Physician Assistant and who assumes the full responsibility for this person's activity under supervision. The other type is the Nurse Practitioner, who is an extended Nurse. Several types of these include Family Nurse Practitioner, Pediatric Nurse Practitioner, Nurse Anesthetist and Nurse Midwife, although the Nurse Anesthetist and Midwife are more likely physician extenders.

We discussed the functions of the Physician Assistant. In general, there are about seven major functions. The Physician Assistant may do triage. He may treat minor problems such as colds, screen well patients such as well babies, or do the routine histories and physicals for insurance examinations or camp physicals. The Physician Assistant may also take part in health education and preventive medicine. The Physician Assistant may also perform histories and physicals on new patients and will be trained in the monitoring of patients with chronic diseases, using predesignated guidelines.

Our discussion group also considered some of the major issues facing the profession, with the new emerging health professionals. Some of these issues have to do with acceptance—first of all by the profession itself—the physician. We also considered public, or consumer acceptance, as well as acceptance by other health professionals. Another problem or major issue considered had to do with the value of the Physician Assistant, to the physician or to the health care team. Another issue considered concerned the quality of care provided and the whole

realm of problems dealing with legal aspects. This raised the question of licensure and certification as well as the problem of what legislation is required to cover the services provided by a Physician Assistant.

The financial aspect was also considered as another major issue related to how a Physician Assistant is to be paid—how to charge for his service. We also discussed the need today for the emerging health professional, as well as the need in the future. A general discussion followed regarding what is happening to the physician population as the nationwide output of physicians increases and what effect this may have on the need for Physician Assistants.

The problem of maldistribution of physicians as related to the health care delivery system was discussed. Dr. Murray presented the results of a survey which he had made, showing the major reason for many physicians leaving primary care practice in rural areas to be the fact that the doctors felt isolated and that they were overworked. We discussed how to go about solving the problem of distribution and decided that rather than have outside agencies come in to tell communities how to solve the problem, the problem should really be studied and planned at the local level. Our group felt that people within the community should determine their own needs and plan the solution themselves, with consultation from outside, if needed.

Finally, our group discussed how to go about delivering more and better primary care to people, disregarding the distribution of care. We decided that we should go about this by doing several things. One, which is obvious, is to produce more doctors, either by training them or importing them, particularly training more primary care physicians. Another thing that was considered was the better organization of the presentation and delivery of health care. In this regard, we discussed solo practice vs. group practice and felt that solo practice is not the efficient way to practice. Our group felt that this is one reason why many physicians are leaving medically deprived areas. Better organization of practice methods was felt to be an important method of delivering more and better care. In addition, the use of new technology, improving the efficiency of practice through this method, would be helpful. All of these recommendations were considered to have a long-range effect. An immediate effect that was discussed was that of the delegation of duties by the use of new allied health



professionals as one way to improve the delivery of medical care now. This was the central theme of our workshop.

In closing the discussion group, one of the participants who, in his own words, "did not have a vested interest" called for a vote about the feeling of our workshop group with relation to the acceptance of Physician Assistants or the new allied health professional. The majority of the group voted approval of the concept. A few weren't sure and several voted No.

In presenting this report to all of the participants of the retreat the same question was raised, polling the entire group. The final vote of the entire group was overwhelmingly to accept, with only one or two uncertain, and only one not accepting.

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3. Royer, Jerry A.; Egger, Ross L.; and Beering, Steven C.: The 1972 Student-Faculty-Physician Retreat, *JISMA*, 65:931-933, Sept. 1972.

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c. Council on Health Manpower and Council on Rural Health: Priorities for Increasing Availability of Health Services in Rural Areas, *JAMA*, 222: 1284-85, Dec. 1972.

d. House of Delegates, AMA: Recommended Definition of the Role of a Primary Care Physician - C-72 - Clinical Meeting, Cincinnati, Dec. 1972.

Appendix A

Saturday, April 7

1:30 - 2:00 P.M.	— Registration Lobby — Ramada Inn
2:00 - 3:00 P.M.	— Opening Plenary Session Presiding — Patrick J. V. Corcoran, M.D. Chairman, Planning Committee Remarks — James H. Gosman, M.D. President, Indiana State Medical Association and Steven C. Beering, M.D. Associate Dean, Indiana University School of Medicine (1) Brief Review of Previous Retreats (2) Retreat Format and Procedures (3) Trends in Evaluation of Quality of Medical Care, including PSRO (Dr. Gosman)
3:15 - 5:00 P.M.	— Group Seminars Primary Medical Care — Dr. A. Alan Fischer, Moderator — Dr. Ross L. Egger, Discussion Leader — Mr. Garre Blair, Recorder Access to Health Care — Dr. Richard N. French, Moderator — Dr. John S. Farquhar, Jr., Discussion Leader — Mr. Michael Bubb, Recorder Team Care Concept — Dr. James E. Carter, Moderator — Dr. Merritt O. Alcorn, Discussion Leader — Mr. Greg Larkin, Recorder Emerging Health Professionals — Dr. Raymond H. Murray, Moderator — Dr. Franklin A. Bryan, Discussion Leader — Mr. Fred Mashan, Recorder
6:00 P.M.	— Reception — ISMA — Host
7:00 P.M.	— Dinner
8:00 P.M.	— Illustrated Film — Sound Strip "Sorry, Socrates"
Remainder of the Evening	Informal Social Interaction



Sunday, April 8

- 8:30 A.M. — Buffet Breakfast
- 9:15 - 11:00 A.M. — Groups Reconvene as Constituted Saturday Afternoon
- 11:00 - 12:00 noon — Summary Plenary Session  
(1) Reports from Group Seminars  
(2) Summaries — Dr. Beering and Dr. Gosman  
(3) Recommendations and Suggestions by Participants
- 12:30 P.M. — Luncheon
- 1:30 P.M. — Adjournment

## Appendix B

### PARTICIPANTS

**Students:** C. W. Acher, Bill Beeson, Garre Blair, Mike Bubb, Jack Deckard, Pete Delevett, Mary K. Dineen, Gerry Hippensteel, Bob Hooker, John Johnson, Ed Keppler, Rich Kiosky, Ron Kracke, Greg Larkin, Clarke Marquadt, Fred Mashan, Kathy Meador, Mike Milan, John Pankey, Bill Silvers, Pat Walker.

**House Officers:** William Gilbert, M.D., James Goldyn, M. D., John Hudson, M. D., Robert Hunter, M. D., Terry Nosziger, M. D., Steve VanVoorst, M. D.

**School of Medicine:** Duke H. Baker, M. D., Steven C. Beering, M. D., Steven D. Berkshire, B. S., Henry R. Besch, Jr., Ph.D., James E. Carter, M. D., A. Alan Fischer, M. D., Richard N. French, Jr., M. D., David M. Gibson, M. D., Horton A. Johnson, M. D., Walter W. Jolly, M. D., Karen Lake, M. A., Richard

E. Lindseth, M. D., A. Donald Merritt, M. D., Ward W. Moore, Ph. D., Raymond H. Murray, M. D., James D. Northway, M. D., Richard C. Powell, M. D., Nancy C. A. Roeske, M. D., Roger W. Roeske, Ph.D., William A. Summers, Ph.D., August M. Watanabe, M. D.

**ISMA:** Merritt O. Alcorn, M. D., Franklin A. Bryan, M. D., Mr. Kenneth W. Bush, Daniel H. Cannon, M. D., Patrick J. V. Corcoran, M. D., Betty Dukes, M. D., Joe Dukes, M. D., Ross L. Egger, M. D., Thomas A. Elliott, M. D., John S. Farquhar, M. D., James H. Gosman, M. D., Lloyd L. Hill, M. D., Paul Inlow, M. D., Harold Manifold, M. D., Bernard B. Rosenblatt, M. D., Mrs. W. W. Stogsdill, Gilbert M. Wilhelmus, M. D., Mr. James A. Waggener.

**AMA:** Richard L. Egan, M. D., Council on Medical Education, Chicago.

### PLANNING COMMITTEE

Steven C. Beering, M. D., Associate Dean, Mr. Steven D. Berkshire, B. S., Assistant to the Dean, Franklin A. Bryan, M. D., Chairman, Commission on Medical Education and Licensure, Mr. Kenneth W. Bush, Administrative Assistant, ISMA, James E. Carter, M.D., Associate Dean for Student Affairs, Patrick J. V. Corcoran, M.D., Chairman, Ross L. Egger, M. D., Vice Chairman, Commission on Medical Education and Licensure, James H. Gosman, M. D., President ISMA. ◀

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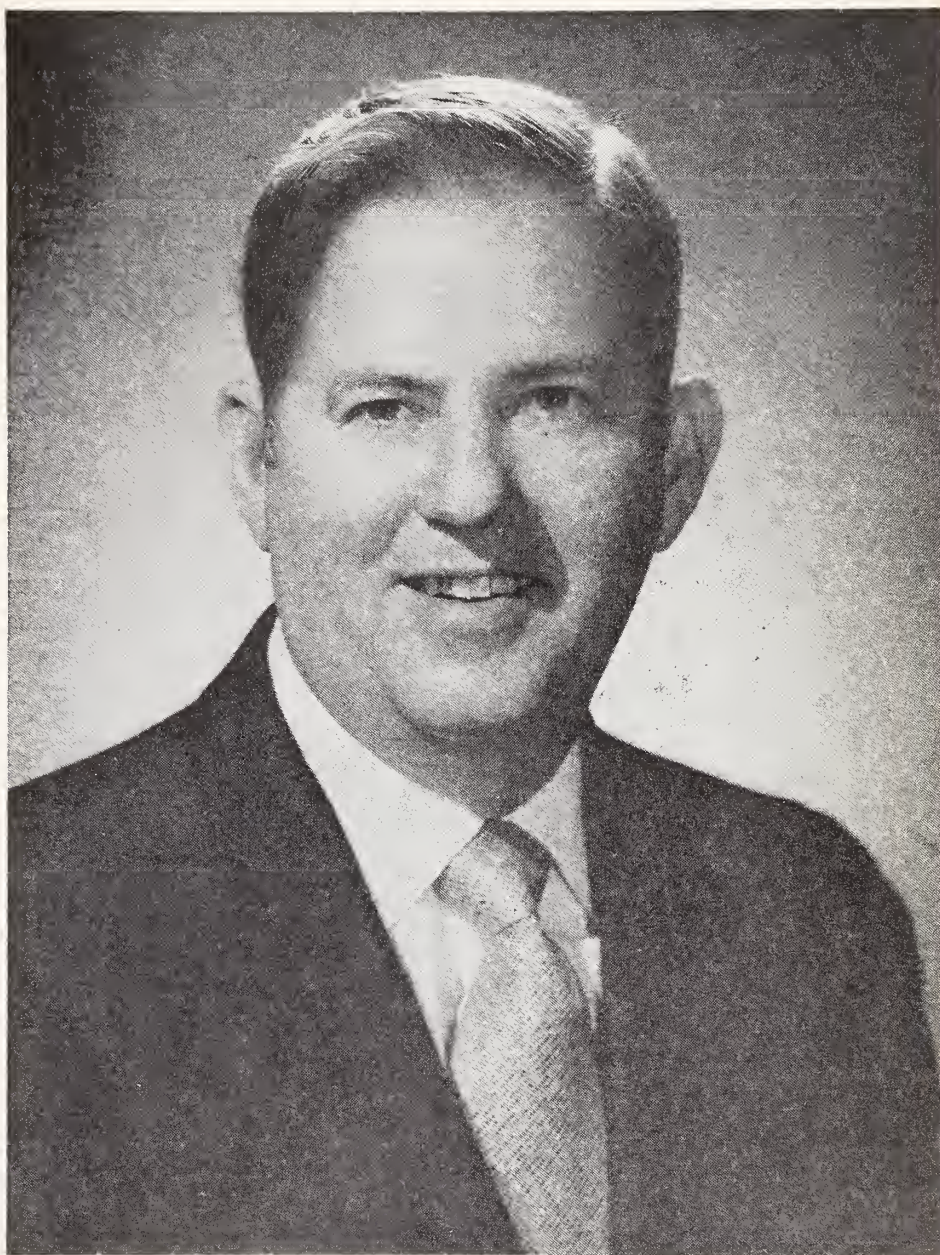


JOE DUKES, M.D.

President

Indiana State Medical Association

1973-74



**D**R. JOSEPH E. DUKES, having served for the past year as president-elect, was installed as president of the Indiana State Medical Association at the Annual Meeting in October.

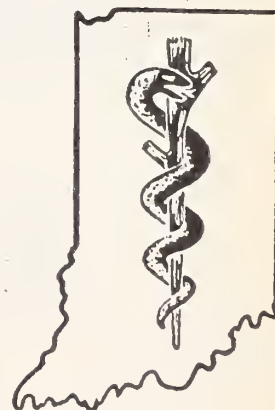
Dr. Dukes has devoted a large proportion of his professional life in the service of the medical profession and in its organizational activities. His many committee assignments, his many terms as Trustee of ISMA, and his great interest over a long period in the Indiana Blue Shield Board of Directors and in its Executive Committee are eloquent testimony to his interest in organized medical affairs.

Dr. Dukes has been engaged in the private practice of general medicine in his home town of Dugger since he completed his internship in the Marion County General Hospital. His wife, Dr. Betty Dukes, is associated with him in the practice. They have three sons, Michael and Russell, both of whom are physicians, and Robert who is busy with postgraduate studies at Indiana University.

Dr. Dukes' community activities include service as Sullivan County Health Officer. He is chairman of the Board of Directors of the Farmers State Bank of Sullivan.

He is a member of the medical staff of the Mary Sherman Hospital of Sullivan. He is also a member of the American Association of Physicians and Surgeons.

Immediately preceding his term as president-elect he was chairman of the Board of Trustees of ISMA.







## TAX TIPS

by LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

Based upon a recent case (and other prior ones), you should have your lawyer review all of your trusts, where the trusts grant a power of appointment to a surviving spouse. If the surviving spouse is granted a *general* power of appointment, then such spouse will generally be taxed upon the corpus of the trust when such spouse dies. See I.R.C. §2041. This is the type of power that is granted to a surviving spouse in order to qualify a marital trust (Trust A) for the federal estate tax marital deduction. However, as I have stated, such a power will cause the surviving spouse to be taxed on the trust funds for estate tax purposes when the surviving spouse dies.

On the other hand, in order to avoid having a non-marital trust (Trust B) taxed, for estate tax purposes, to the surviving spouse, such spouse is often granted a *special*

(or limited) power of appointment in the non-marital trust.

In order for a power of appointment to be a special power of appointment, rather than a general power of appointment, the power has to be limited by an ascertainable standard which relates to the surviving spouse's health, education, support, or maintenance. In attempting to *broaden* a special power, lawyers frequently allow the power to be exercised for such spouse's health, education, support and maintenance *and* for the spouse's *comfort* and *benefit*. It now seems clear that such standards as *comfort* and *benefit* are too broad and that the use of these terms may convert a special power into a general power. This, in turn, will cause the surviving spouse to be taxed on the trust funds at the spouse's death.

Therefore, you would be wise to have your lawyer review your trust instruments now. Make certain that the exercise of powers, which are intended to be special powers, are limited by such standards as health, education, support or maintenance—and no broader ones. Otherwise, your client will be risking significant and adverse estate tax consequences. See *Doyle v. U. S.* (D.C., Pa.) P-H §147, 856. Personally, I think that it is generally more prudent (as well as safer, tax-wise) to grant to the trustee broad discretionary powers over the funds of the non-marital trust, and to not grant even special powers to the surviving spouse.

If any of you own businesses which are members of business associations which are exempt from

income tax because they are business leagues, then tell such associations to beware. The I.R.S. is currently making a study in order to determine how such organizations should be taxed, for income tax purposes, on the rents which they receive from such things as display space at conventions. Consider the various professional associations to which you belong.

At the same time, the I.R.S. intends to reconsider its present position (which allows an income tax exemption) to shopping center associations. The result of the study may be to deny such associations an income tax exemption where such associations pay for advertising for their members or restrict their memberships and mandate that stores within the shopping center limits must be members of the association. Also, the I.R.S. is considering taxing (for income tax purposes) all revenues or fees or contributions which are made by the members of the associations and which exceed the association's expenses.

Also, if any of you serve on any political committees or parties, then you had better tell their legal counsel to begin following the tax reports which concern the I.R.S.' new views on the taxation of such organizations. For the I.R.S. intends to, among other things, make such associations file tax returns and to pay income tax on interest, dividends, gains from the sales of properties, etc. Political contributions will not be taxed, nor will expenditures for political purposes be deductible. ◀

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Ⓜ Phenaphen with Codeine is now classified in Schedule III, Controlled Substances Act of 1970. Available on written or oral prescription and may be refilled 5 times within 6 months, unless restricted by state law.

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## ABSTRACTS, BOOK REVIEWS

### VASCULAR DISORDERS AND HEARING DEFECTS

From a symposium held at Johns Hopkins Medical School April 1972; edited by A. J. Darin de Lorenzo, Ph.D., M.D., and sponsored by the Information Center for Hearing, Speech and Disorders of Human Communication; University Park Press, Baltimore; 1973; from 3 to 15 illustrations in each of the 17 chapters; \$17.50.

First, let us clear up some confusing hangovers from freshman medical school days. The Eighth Cranial Nerve is called the Nervus Acusticus: "obviously," the hearing nerve. Well: It has *two* separate parts: a) Nervus Vestibularis, which deals with equilibrium and *not* hearing; b) Nervus Cochlearis, which comes from the cochlea and *is* the hearing nerve. This symposium concerns itself only with the cochlear nerve.

The core of this symposium deals with the recondite and abstruse aspects of the circulation of the cochlea. The distinguished specialists present the latest clinical and experimental investigations on the basic mechanisms of the vascular structure, physiology and pharmacology as they relate to hearing defects.

I doubt whether even the average otologist would be capable of a knowledgeable analysis of the material here printed for his delectation. I just know that I am not in a position to do so. Sir, Super-specialist: There it is; do with it as you will.

The paper, binding and printing are good; the cuts are superb. The typos are few and do not obscure the meanings intended. For my part, the most arresting bit of knowledge acquired was the fact that there is such an entity as "The Information Center for Hearing, Speech and Disorders of Human Communication." The Frontiers of Medical Knowledge are really expanding at a logarithmic pace. But that is really nothing new even if the particular item stressed was news to me.

ARNOLD LIEBERMAN, M.D.  
New York

### REVIEW OF PHYSIOLOGICAL CHEMISTRY

H. A. Harper, 14th edition, Lange Medical Publications, Los Altos, Calif., 1973.

In the 14th edition of REVIEW OF PHYSIOLOGICAL CHEMISTRY we have another of the time-tested Lange Medical Publications. Although termed a "review," the volume is more than that. It represents an excellent textbook that should meet the needs of even the most scientifically inclined practitioners of medicine. The primary author is Harold A. Harper, Ph.D., Professor of Biochemistry, University of California School of Medicine, San Francisco. The 14th edition contains important contributions by Drs. Gerold M. Grodsky, Peter A. Mayes, and Victor Rodwell, and, in addition, those of Dr. Tawfik ElAttar. The strikingly clear illustrations reflect the skills of Ms. Laurel V. Schaubert.

While the text does indeed present the basics of physiological chemistry, it also covers in splendid detail the clinical implications. As an example, Chapter 17 covers not only liver functions but the physiologic and chemical basis for tests of liver function. Remembering those of us who have been out of school for awhile, the appendix offers a splendid summary of general and physical chemistry, a brief review of organic chemistry by Victor Rodwell (and how we of the class of '38 need that!), and finally, most useful, abbreviations and alternative terminology frequently used in physiological chemistry. The writing is lucid, which it would have to be to be translated into French, Spanish, Italian, Polish, Portuguese and Japanese, which it has been.

Now a word as to the illustrations. These Schaubert productions are clear, clean and simple, yet all are striking. I have never seen a better summary of the normal physiology of the nephron than is pictured in Fig. 18-3, and the other illustrations are of equivalent caliber.

The book is nicely bound in a tough, flexible, plastic cover and is beautifully priced at only \$8.50 for its 545 pages. It looks to me as though Lange Medical Publications of Los Altos, California, has scored again.

W. D. SNIVELY, JR., M.D.  
Evansville

### SICKLE CELL HEMOGLOBIN: MOLECULE TO MAN

Makio Murayama, Ph.D., and Robert M. Nalbandian, M.D., Little, Brown and Co., Medical Division, Boston, 1973; some 70-odd illustrations; 198 pages; \$16.50.

Continued

## NEW PROSTHETIC METHODS OPEN NEW DOORS

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It is a real thrill to have lived long enough to encounter—ever so unexpectedly—this outwardly quite unprepossessing monograph which turns out to be really in a new genre: the first of a new breed that will give biochemical answers to genetic problems. We'll be able to stop the discourse on genomes, dominance, recessiveness, penetrance and all the vocabulary of genetics that has only underscored our basic helplessness at really *doing* something anent the problem raised: cystic fibrosis, trisomy 21, Amaurotic familial idiocy, or what have you.

With a minimum of verbosity, the authors present the actual molecular structure of normal hemoglobin: this is not really new but bears repeating. Then, the authors discuss the bioenergetics of human red cell sickling and an actual chemical model of the mechanism of sickling. What is the structural error? Well! "Precision scale models of sickle cell hemoglobin molecules indicate that the *genetic substitution* of valine for glutamic acid at the sixth position in the Beta chains allows an intermolecular hydrophobic bond to form" (p. 43). This bonding permits head-to-tail molecular stacking by a "lock-and-key" arrangement. Can anything be more concise and precise?

What to do? This—now strictly chemical—problem was handled via test tube experiments. It was determined that urea, yes, the well known urea, when added in proper quantities under specific physical conditions easily tolerated by the living body, would unlock the molecular stacking and resolve the crisis. Human volunteers were easy to find; the scheme worked! Precise dosages and best routes of administration were worked out in meticulous detail!

So! For the first time (to my knowledge) a genetic problem has been solved by purely biochemical means. The individual still has the valine in the wrong place but now he can prevent the nasty problems that previously were all but unsolvable. The day may even come when the genetic engineer will inject into the bone marrow the chemical that will correct the error at the source.

The references are voluminous; the paper, binding and printing are up to standard. This volume deserves a niche on hospital library shelves. I would urge ALL doctors to scan it at least once.

ARNOLD LIEBERMAN, M.D.  
New York



## TEXTBOOK OF MEDICAL PHYSIOLOGY

Arthur C. Guyton, M.D., W. B. Saunders Co., Philadelphia, 1973; fourth edition; 556 pages, 214 illustrations; \$18.50.

The continuing literature explosion makes it ever more difficult to survey any given area of science and keep abreast of the just acquired bits of information. Just in the field of physiology (in which I acquired a Ph.D. a few decades ago), I possess a whole shelf of recent volumes covering various facets of this topic. The previous editions of Guyton's monograph had not attracted me unduly. This fourth edition did! I first thumbed my way through various chapters savoring the author's style and erudition on items that had attracted my attention.

Frankly, I was delighted; and amazed at my previous indifference: The illustrations are well chosen, well made and quite clear as to meaning when the text is perused. The chapters are long enough yet avoid mere verbiage. The references are complete without being overabundant. The appendix is an open sesame to the desired subject.

Typographical errors are all but non-existent; the paper, printing and binding are superb. The use of a word such as "dissolutes" (on p. 142) might be considered a solecism; still, it *is* in the dictionary!

Altogether: a pleasure and a joy! The author is to be congratulated on his erudition; the publisher, ditto on the format and modest price. Personally, I'm pleased to have had the privilege of reviewing this splendid updating of such a model one-man effort.

ARNOLD LIEBERMAN, M.D.  
New York

## MODERN CLINICAL PSYCHIATRY

Lawrence C. Kolb, M.D., W. B. Saunders Co., Philadelphia, 1973; eighth edition; 694 pages; \$13.00.

The *fifth* edition (then, "NOYES & KOLB") was reviewed by "yours truly" in *Geriatrics* Vol. 14, #3, March 1959. At that time I commented on the fact of increasing biochemical understanding of just *how* the neo-pallium—that uniquely human mass of tissues—makes possible a dawning understanding of "short term" and "long term" memory. We were getting away from the strictly psychiatric use of terms such as "affect," "cognition," "conation," and other such arcane descriptions of mental disease processes.

Well! a dozen-plus years later, Dr. Kolb really goes all out to prove that psychiatry has come a long way toward being a really *medical* discipline! An internist such as myself, any just-graduated intern or even an intelligent lay pedagogue can thread his way through this concise, compact, lucidly written volume and really be informed. An excellent index gives easy access to just the topic under scrutiny.

Some newly included chapters are almost too facile in seeming to promise more than they can deliver! This does not detract from the interest given by perusal of chapters such as "Pharmacological Therapy," "Drug Dependence," "Brain Disorders Associated With Endocrine, Metabolic and Nutritional Disorders," etc.

Diagrams, illustrations and even formulae might have added to the thrust of the presentations. The paper, binding and printing are a credit to the publisher. Altogether: still, THE leading text in its field!

Too bad that Dr. Arthur B. Noyes has been gone this last decade! I'm thinking that he would have been proud of the



work being carried on by his successor!

ARNOLD LIEBERMAN, M.D.  
New York

Abstracts from Various  
Literature, Prepared by AMA

**BLEOMYCIN—NEW APPROACH IN CANCER  
CHEMOTHERAPY**

F. O. STEPHENS (Sydney Hosp, Sydney, Australia)  
*Med. J. Aust.* 1:1277-1283 (June 30) 1973

Fifteen patients with advanced squamous carcinomata have been treated with the new antitumor antibiotic, bleomycin. In 10 patients there was objective evidence of regression of the tumor ranging from moderate or temporary regression in some patients to apparent complete remission in others. In one further patient there was dramatic improvement when bleomycin was used in conjunction with the antimetabolite, methotrexate. Some troublesome, but temporary, side effects were observed, including considerable loss of hair in five patients and significant pulmonary fibrosis in one.

**CROMOLYN PROPHYLAXIS FOR  
CHRONIC ASTHMA**

J. S. HYDE (Rush Medical Center, Chicago 60612)  
*Ann. Intern. Med.* 78:966 (June) 1973.  
Overall results suggest that about 20% of adult asthmatic

patients respond dramatically to cromolyn sodium, with a further 30% showing worthwhile but less striking benefit. The response percentages are somewhat higher in children. Long-term effects have been assessed by one-year double-blind studies and by longer open trials using objective measurements of efficacy and safety. Desirable clinical results depend greatly on judicious selection of patients and regular use of prophylactic cromolyn and other background antiasthma drugs. The best response occurs in patients who can be classified as labile by the variability in their pulmonary function measurements. The drug should never be used as symptomatic therapy, particularly of the acute attack, since this is completely at variance with its mode of action.

**RISK OF CANCER IN RENAL TRANSPLANT  
RECIPIENTS**

R. HOOVER (Room A521, Landow Building, NIH, Bethesda, Md. 20014) and J. F. FRAUMENI, Jr.,  
*Lancet* 2:55-56 (July 14) 1973.

Among 6,297 individuals reported to a kidney transplant registry, the risk of developing lymphoma was about 35 times higher than normal and was derived almost entirely from a risk of reticulum cell sarcoma, which was 350 times greater than expected. The excess lymphoma risk appeared within a year of transplantation, and remained at the same high level for the five or more years of follow-up. Skin and lip cancers occurred up to four times more often than expected. Other cancers were two to five times more common, in men only, due largely to soft tissue sarcoma and hepatobiliary carcinoma. ◀

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# Annual Meeting Dates of Professional Medical and Allied Organizations

## AMERICAN MEDICAL ASSOCIATION ANNUAL CONVENTION

Date Dec. 1-5, 1973  
Place Anaheim, Calif.

## NORTHERN INDIANA PSYCHIATRIC SOCIETY

Date Fourth Wednesday of every  
month, September through June  
Place For location and program, inquire  
Jon Leipold, M.D.,  
919 E. Jefferson Blvd.  
South Bend 46622

## INDIANA STATE MEDICAL ASSOCIATION CONVENTION

Date October 7-9, 1974  
Place Indianapolis

## INDIANA ACADEMY OF FAMILY PHYSICIANS

Date April 2-4, 1974  
Place Stouffer's Indianapolis Inn

## INDIANA PSYCHIATRIC SOCIETY

Date Second Wednesday of September,  
November, January, February,  
March and April  
Place For time and place, inquire Wes-  
ley A. Kissel, M.D., 1815 N.  
Capitol Ave., Indianapolis 46202

## INDIANA ASSOCIATION OF PATHOLOGISTS

Date December 1, 1973  
Place Indianapolis

## INDIANA THORACIC SOCIETY

Date May 7-8, 1974  
Place Indianapolis

## INDIANA CHAPTER, AMERICAN ACADEMY OF PEDIATRICS

Date Sept. 26-27, 1973  
Place Ramada Inn, Nashville

## INDIANA LUNG ASSOCIATION

Date May 7-8, 1974  
Place Indianapolis

## INDIANA ACADEMY OF OPHTHAL- MOLOGY AND OTOLARYNGOLOGY

Date May 7-9, 1974  
Place Sheraton, French Lick

## INTERNATIONAL COLLEGE OF SURGEONS

Date December 1, 1973  
Place Indianapolis

## INDIANA PUBLIC HEALTH ASSOCIATION, INC.

Date April 16-18, 1974  
Place Stouffer's Indianapolis Inn

## INDIANA SOCIETY OF ANESTHESIOLOGISTS

Date March 23, 1974  
Place Indianapolis Hilton

## INDIANA SOCIETY—AMERICAN ASS'N OF MEDICAL ASSISTANTS

Date April 26-28, 1974  
Place Ramada Inn, Nashville

## INDIANA DENTAL ASSOCIATION

Date May 4-7, 1974  
Place Convention-Exposition Center,  
Indianapolis



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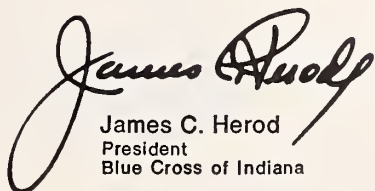
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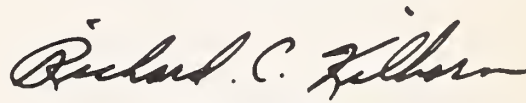
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## JCAH Rules On Repeat Tests

The Joint Commission on Accreditation of Hospitals (JCAH) issued the following statement on repetition of diagnostic tests as a result of liaison meetings between the National Association of Blue Shield Plans and the Blue Cross Association with medical and institutional organizations. The statement reiterates the Commission's past policy of record.

"A question that often arises is in regard to the repetition of diagnostic tests in the hospital following similar tests performed in doctors' offices or by independent laboratories prior to admission of the patient.

"Would a facility's accreditation status be affected if such tests were not repeated upon admission of the patient? No.

"The new hospital Standards of the Joint Commissions are silent on the question of clinical demands regarding routine admission laboratory work. These questions are left to the medical staff at the local level for its own decision, and the only reference the Joint Commission Standards make to pre-admission testing is the fact that, if locally required laboratory work is done by a laboratory approved by the medical staff.

"Laboratory results that have been ordered by the doctor in his office are often entered as information in the patient's admission history as being informative to the physician, without the hospital assuming official responsibility for the record.

"If a physician chooses not to repeat, upon admission of the patient, diagnostic and laboratory tests which have been conducted in the doctor's office or by an independent laboratory, the Joint Commission will not object, so long as he adheres to the policies adopted by the medical staff." — **Reprinted from The Bulletin of the American College of Radiology, September 1973.**

## Two Receive Mead Johnson Awards

The E. Mead Johnson Awards in pediatrics this year will be given to Henry L. Nadler, M.D., of Northwestern University Medical School, and James G. White, M.D., of the University of Minnesota. The awards are given for outstanding research in pediatrics. Each award includes \$3000, a sheepskin scroll and a certificate.

## 356 Medical Assistants Achieve Certification

A record number of 356 medical assistants became Certified Medical Assistants by successfully passing the 1973 Certification examination conducted by the American Association of Medical Assistants. In Indiana Sondra Wright of Piercetown qualified in both administrative and clinical categories. Neva Arnold of Indianapolis, Mary Clark of Indianapolis and Kathryn Kijovsky of Indianapolis all qualified in the clinical category.

## Pharmaceutical Industry Prepares for Hearings Before Senate Health Subcommittee

Major legislative hearings on the pharmaceutical industry, slated to begin this fall before the Health Subcommittee of the Senate Labor and Public Welfare Committee, are expected to cover such basic areas as marketing practices, research and physician prescribing habits. The Subcommittee, chaired by Senator Edward Kennedy (D., Mass.), will presumably develop legislative proposals in the course of a planned schedule of about three days of hearings a month over a nine-month span. The Pharmaceutical Manufacturers Association and several individual companies will no doubt testify, along with individuals and groups in medicine and in related health care fields.

While the industry has been subjected to much scrutiny on Capitol Hill for many years, the hearings before Senator Kennedy could have more impact because they are designed to produce legislative proposals. The six years of sporadic hearings before the Monopoly Subcommittee of the Senate Small Business Committee chaired by Senator Gaylord Nelson (D., Wis.) were investigative only. Senator Nelson introduced a number of bills in the course of his hearings, which are pending before the Kennedy Subcommittee.

Announcement of the hearings came in a speech delivered on July 22 by Senator Kennedy at the annual meeting of the American Pharmaceutical Association in Boston. Meanwhile, the industry, through PMA, has been gearing for extensive testimony. In a recent speech, C. Joseph Stetler, PMA president, said that "we have reason to expect that these hearings will be conducted fairly and responsibly."

It seems clear that as the hearings proceed the role of medicine and physicians in matters of drug therapy will continually surface, and that the stake of medicine will be as vital as that of the industry in any legislative outcome.—*National Pharmaceutical News, October 1973.*

## Dr. Harvey Will Head Staff

**Dr. David Harvey of Munster** has been elected president of the medical staff of the new Munster Community Hospital. **Dr. John Lanman** was elected first vice president and **Dr. William Hehemann** was elected treasurer.

## Dr. Zink Appointed

**Dr. Robert O. Zink, Madison**, was recently appointed to a four-year term on the Madison Consolidated School Board of Trustees. He has served previously on this board.

## Publishes Bowen Article

An article written by **Governor Otis R. Bowen** describing the Indiana Program for Statewide Medical Education has been published in the current issue of *Compact*, the publication of the Education Commission of the States. Governor Bowen serves on the steering committee of the Education Commission and his article is based on a speech he delivered to the ECS annual meeting.

## New Health Chief Named

**Dr. Everett E. Bickers**, a general practitioner with offices at Floyds Knobs, was recently appointed commissioner of the joint New Albany-Floyd County Department of Health.



## Fire Protection Booklets Offered

The National Fire Protection Association has a 48-page booklet "Tentative Recommended Practice for Electrical Equipment Maintenance" on sale for \$1.50. There is also a 4-page pamphlet on "Standard on Basic Classification of Flammable and Combustible Liquids" for \$1.00. The address is 60 Batterymarch St., Boston 02110.

## Eaton to Provide 100 Schools with Color Videocassette Players, Films

Eaton Laboratories is providing color videocassette players and TV receivers to urology departments in 100 medical teaching institutions throughout the United States. This is a part of Eaton's undergraduate and postgraduate medical education program. Twenty-two teaching films from Eaton's Film Library will be included in the gift. Indiana University School of Medicine and the Methodist Hospital of Indiana at Indianapolis are two of the designated recipients.

## Issue of Unapproved Use of Approved Drugs Surfaces Again

In upholding the physician's right to prescribe approved drugs for indications not specifically approved by FDA, Dr. Alexander MacKay Schmidt, the new Commissioner of Food and Drugs, has brought to the surface again a controversy that has been simmering for several years between the Food and Drug Administration and the medical profession. Schmidt's philosophy, as expressed at his inaugural press conference July 26, seems to conflict with the underlying policy of the agency, as it emerged in regulations proposed just over a year ago.

Although FDA officially acknowledged the physician's right to use approved medications for unauthorized conditions without prior approval, the August 15, 1972, proposal made it clear that the agency intends to take action when unapproved use of a particular drug becomes widespread or creates a public health hazard. FDA has insisted that it will not, and cannot under law, interfere with the practice of medicine. Yet through its regulation of drug manufacturers FDA would attempt to regulate to some degree this physician's use of drugs.

Dr. Schmidt, former dean and professor of medicine at the

University of Chicago's Abraham Lincoln School of Medicine, told reporters he operates on the assumption that physicians are scientists and their medical judgments are, therefore, made on a scientific basis. "If an M.D. uses a drug for an indication not given in the package insert, or given by the FDA," he said, "it is, I believe, a safe assumption that he is doing it for a rational reason and will be able to explain the reason. There is no prohibition, nor should there be any prohibition, in my mind to an M.D. using a drug for a condition other than that commonly accepted."

The only requirement, Schmidt suggested, should be that physicians be able to explain the rationale for prescribing a particular drug for a certain unapproved condition.

The issue is expected to be brought up again in the fall when Senator Edward Kennedy (D., Mass.) and his health subcommittee begin "a major set of legislative hearings" on the pharmaceutical industry. During Kennedy's hearings on biomedical research and human experimentation last February the same question arose, centering on reports of widespread use of diethylstilbestrol (DES) and Depo Provera (an Upjohn product) as contraceptives without FDA approval. [Since then DES has been approved as a postcoital contraceptive in emergency situations.] At that time Dr. Charles Edwards, then FDA commissioner and now HEW assistant secretary for health, repeated the agency policy outlined in the 1972 proposal. He insisted that FDA won't attempt to control medical practice, yet he urged physicians to submit investigational new drug plans before prescribing drugs for unapproved indications and to report the results to the agency. He also warned that FDA will take action if patterns of unapproved use develop for a certain drug.

In opening the series of hearings on clinical research February 21, Chairman Kennedy said, "When a physician prescribes a drug for a purpose other than that for which it has been approved, he is performing an experiment. And in the absence of sufficient quality control mechanisms, his latitude to perform such experiments is nearly unlimited. . . . The question is whether or not we can tolerate a system where the individual physician is the sole determinant of the safety of an experimental procedure." It is possible that Kennedy's answer to his question will be in legislation to regulate the unapproved use of drugs through a drug utilization review mechanism, after the issue has been further explored during the upcoming hearings.—*National Pharmaceutical News*, October 1973.



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## NEWS NOTES

Continued

### Dr. Dahling Heads Staff

**Dr. Fred Dahling, New Haven**, has assumed the duties of president of the Fort Wayne Lutheran Hospital Medical Staff for 1973-74. Also serving for the current year are: **Dr. Allen Aldred**, president-elect; **Dr. Don Miller**, secretary, and **Dr. Richard Bower**, treasurer.

Members of the executive committee include **Dr. Lloyd Vogel**, chairman, and **Dr. Aldred, Dr. George Bowers, Dr. Wayne Hardin, Dr. Alan Richards** and **Dr. Dahling**.

### Dr. Reynolds Wade Certified

**Dr. Reynolds W. Wade, Fort Wayne**, has been certified by the American Board of Abdominal Surgery. He was named diplomate of that board following completion of examinations in Chicago.

### Recognized for Cancer Work

**Dr. Roger Robison, Bloomington**, was the first person selected for recognition on the **Dr. Cyrus Houshmand Memorial Plaque** to be displayed in the Bloomington Hospital. The plaque was presented to him by **Dr. Larry Ratts**, president of the Monroe County Cancer Society.

### Elected Museum Trustee

**Dr. John Pittman, Indianapolis**, has been elected a trustee of the Children's Museum of Indianapolis. The museum is trying to raise \$3.5 million to match a \$3.5 million Lilly Endowment challenge grant to expand its facilities.

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### Dr. Gray Named by Lions Club

**Dr. William J. Gray**, a general practitioner, has been elected president of the Anderson Lions Club.

### Dr. Harshman Appointed

**Dr. James Harshman, Kokomo**, has been named to a one-year term on the Kokomo Plan Commission.

### Dr. Doan Named Team Physician

**Dr. John E. Doan, Decatur**, served as team physician for the AAU wrestling team which represented the United States in the World Games in Iran in September.

### Doctors to Aid Clay County Library

To match a grant-in-aid awarded the Clay County Hospital at Brazil, every member of the hospital medical staff has agreed to donate \$100 to finance the total library project request.

The \$1,500 grant which the hospital received is from the Indiana University Medical School. The funds which the school administers and disburses are from special educational funds provided by the federal government. The funds will be used to purchase additional books and reference materials for the hospital medical staff library.

### House Staff Honors Four

Four members of the attending staff faculty of the Methodist Hospital (Indianapolis) Graduate Medical Center received distinguished teacher plaques at the annual recognition dinner for outgoing house staff physicians recently.

Honored for "advancing the level of graduate medical education at Methodist Hospital" were: **Dr. George Applegate**, nephrology; **Dr. Edward J. Berman**, pediatric surgery; **Dr. William Elliott**, cardiology; and **Dr. Richard Hutson**, orthopaedics.

### Receives Commendation Medal

**Dr. Gary Babcoke, Chesterton**, battalion surgeon of the 113th Engineers, 38th Division, Indiana National Guard, received the Indiana Commendation Medal last summer at Camp Grayling, Mich. Accompanying the medal is a citation from the Governor commending **Dr. Babcoke** for excellent and meritorious service in the Indiana National Guard.

### Gains Nuclear Certification

**Dr. H. Joseph Cronin, Indianapolis**, was recently notified by the Conjoint American Board of Nuclear Medicine that he had successfully passed its April Certifying Examination.

### Dr. Mericle Honored

**Dr. Earl W. Mericle, Indianapolis**, was honored recently for his years of dedicated service to mentally ill Hoosiers and to the Mental Health Association of Indiana. A replica of the Mental Health Bell was presented to **Dr. Mericle** by **Dr. Joe Dukes** at the MHAI annual banquet. **Dr. Mericle** served on the Association's board of directors for more than 20 years and has been chairman of the MHAI Professional Advisory Committee since its inception.





## About Our Cover

St. Francis Hospital Center, Beech Grove, a member of the Greater Indianapolis Hospital District, last month dedicated a \$14 million, 8-story Center to the existing 300-bed hospital. Twin patient towers add 225 beds to the institution, while ancillary services were re-located to new quarters to the rear of the patient towers.

The new Center features a 15-bed Cardiac Care Unit with an adjoining 12-bed Intensive Care Unit. A new Emergency Department with a staff of six full time physicians expects to receive more than 30,000 patients in the first year. The Lobby entrance features the first escalator in an Indiana hospital, while nearly six miles of pneumatic tubing provides a fast and efficient communications system.

An enclosed ground level passageway connects the new Center to the St. Francis Medical Arts building. This \$3 million facility features a 400-car self-park garage, and 3 floors for custom-designed physician office space.

This marks the third major expansion of the Beech Grove hospital since its founding in 1914 by the Sisters of St. Francis of Perpetual Adoration. The Order of Sisters also operates 10 other hospitals in a five-state area.



# INDIANA STATE BOARD OF HEALTH

## MONTHLY REPORT — September 1973

Disease	Sept. 1973	Aug. 1973	July 1973	Sept. 1972	Sept. 1971
Animal Bites	1122	1165	1413	1400	1236
Chickenpox	46	22	122	51	20
Conjunctivitis	317	190	304	207	146
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	188	72	34	34	42
Gonorrhea	1245	1250	686	1289	910
Impetigo	434	227	259	316	235
Infectious Hepatitis	61	65	45	72	60
Infectious Mononucleosis	89	45	35	211	85
Influenza	2298	1211	1063	2840	584
Measles					
Rubeola	24	7	59	13	18
Rubella	18	12	21	33	72
Meningococcic Meningitis	1	0	0	0	1
Meningitis, Other	4	2	0	2	4
Mumps	48	34	83	32	37
Pertussis (Whooping Cough)	8	3	2	32	6
Pneumonia	419	257	297	352	209
Poliomyelitis	1	0	0	0	0
Streptococcal Infections	1176	655	738	870	639
Syphilis					
Primary & Secondary	36	22	12	22	28
All Other Syphilis	125	116	65	89	120
Tinea Capitis	17	7	8	8	4
Tuberculosis (Active)	60	45	53	86	74

### STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION (Act of August 12, 1970: Section 3685, Title 39, United States Code).

1. Title of Publication: THE JOURNAL of the Indiana State Medical Association.

2. Date of Filing: September 26, 1973.

3. Frequency of issue: Monthly.

4. Location of known office of publication: 3935 N. Meridian St., Indianapolis, Indiana 46208—Marion County.

5. Location of the headquarters or general business offices of the publishers: 3935 N. Meridian St., Indianapolis, Indiana 46208.

6. Names and addresses of publisher, editor, and managing editor: Publisher: Indiana State Medical Association, 3935 N. Meridian St., Indianapolis 46208. Editor: Frank B. Ramsey, M.D., 3266 N. Meridian St., Rm. 705, Indianapolis 46208. Managing editor: James A. Waggener, 3935 N. Meridian St., Indianapolis, Indiana 46208.

7. Owner (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as

well as that of each individual must be given.) Name: Non-profit corporation—No stockholders.

8. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages or other securities (If there are none, so state): None.

9. For optional completion by publishers mailing at the regular rates (Section 132.121, Postal Service Manual). 39 U. S. C. 3626 provides in pertinent part: "No person who would have been entitled to mail matter under former section 4359 of this title shall mail such matter at the rates provided under this subsection unless he files annually with the Postal Service a written request for permission to mail matter at such rates."

In accordance with the provisions of this statute, I hereby request permission to mail the publication named in Item 1 at the reduced postage rates presently authorized by 39 U.S.C. 3626.

(Signature and title of editor, publisher, business manager, or owner).

10. For completion by nonprofit organizations authorized to mail at special rates (Section 132.122, Postal Manual): The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes: Have not changed during preceding 12 months.

### 11. Extent and nature of circulation.

	Average No. of copies each issue during preceding 12 months:	Actual No. of copies of single issue published nearest to filing date:
A. Total No. copies printed (Net press run)	4,799	4,811
B. Paid circulation.		
1. Sales through dealers and carriers, street vendors and counter sales	None	None
2. Mail subscriptions:	4,515	4,480
C. Total paid circulation:	4,515	4,480
D. Free distribution by mail, carrier or other means		
1. Samples, complimentary, and other free copies	231	231
2. Copies distributed to news agents, but not sold	None	None
E. Total Distribution (Sum of C and D)	4,746	4,711
F. Office use, left-over, unaccounted, spoiled after printing:	53	100
G. Total (Sum of E & F—should equal net press run shown in A):	4,799	4,811

I certify that the statements made by me above are correct and complete. James A. Waggener.



# What's New?

Extracorporeal Medical Specialties announces a new cuffed intratracheal tube. It has an unique pressure regulating valve and external pressure control balloon which maintains a lateral wall pressure of 20 to 25 mm Hg on the mucosa to minimize the hazard of scarring and stenosis. Available in six sizes and in both Murphy and Magill tips.

\* \* \*

Reynolds Metals announces new child-safety flexible packaging for pharmaceuticals. Several types of the peelable blister package, which are easily opened by adults but are almost proof against opening by children, have been devised. All have passed the Poison Prevention Packaging Act protocol tests.

\* \* \*

Doubleday has just released "The First Five Years: A Relaxed Approach to Child Care." It is a totally new guide to the care of infants and preschoolers—a compendium of common-sense advice. Authored by Virginia E. Pomeranz, M.D., with Dodi Schultz. 264 pages—\$6.95.

\* \* \*

Halbert Enterprises has an electronic calculator with full four-function (add, subtract, divide and multiply). Comes in a carved walnut case, small enough to fit on desk top. Silent operation, easy to read, weight 5 1/2 lbs., one year guarantee.

\* \* \*

"Guiding Your Child to a More Creative Life" by Fredelle Maynard, Ph.D., has just been released by Doubleday. The mission of the book is to help parents and teachers guide a child in developing his inner resources and sense of self. The author believes that every child is born with a creative instinct and that, regardless of IQ, the talent may be developed fully with proper training. 384 pages, \$7.95.

\* \* \*

Chemetron has a new modular wall equipped with electrical devices for increased safety for electrically susceptible patients. An isolation transformer, an equipotential grounding network and an isolated electric power system monitored continuously for ground fault and distinctive receptacles are features which provide safety. The modular wall is designed for use in areas where patients are attached to monitoring equipment or electrical-electronic equipment by an implanted catheter or electrode.

\* \* \*

## Schedule of Upcoming NCME Programs

Here are the playing dates and upcoming programs to be distributed by The Network for Continuing Medical Education (NCME):

November 5- November 18	<b>RADIOLOGIC MANAGEMENT OF EARLY CANCER OF THE LARYNX</b> , with Alexander D. Crosett, Jr., M.D., Director, Division of Radiation Therapy and Nuclear Medicine at Overlook Hospital, Summit, N.J., and Charles E. Langgaard, M.D., Attending Otolaryngologist, Summit Medical Group, Summit, N.J.
	<b>WHAT CAROTID ARTERIOGRAPHY CAN TELL YOU</b> , with Michael D. F. Deck, M.D., Associate Attending Radiologist and Associate Professor of Radiology at Cornell University Medical Center in New York.
	<b>NATURAL CHILDBIRTH</b> , with Alfred Tanz, M.D., Attending Obstetrician and Gynecologist, Lenox Hill Hospital, and Assistant Clinical Professor, New York Medical College, N.Y.
November 19- December 2	<b>HEARING LOSS: A THREAT AT ANY AGE</b> , with Merrill Goodman, M.D., Director of Otolaryngology at Long

Island Jewish—Hillside Medical Center, and Medical Director of the Long Island Hearing and Speech Center, N.Y.

**TIBETAN MEDICINE: A THOUSAND-YEAR-OLD PRACTICE**, with Donald G. Dawe, Th.D., Professor of Theology, Union Theological Seminary, Richmond, Va., and James L. Mathis, M.D., Professor and Chairman of the Department of Psychiatry, Medical College of Virginia; William Regelson, M.D., Professor and Chairman, Department of Psychiatry, Medical College of Virginia; William Stepka, Ph.D., Professor of Pharmacognosy, School of Pharmacy, Virginia Commonwealth University, Richmond, Va.

**NUCLEAR MEDICINE AND THE COMMUNITY HOSPITAL**, with Alexander D. Crosett, Jr., M.D., Director, Division of Radiation Therapy and Nuclear Medicine at Overlook Hospital, Summit, N.J.

For more information about NCME, write The Network for Continuing Medical Education, 15 Columbus Circle, New York 10023.

(Program schedule subject to change)



# and now there are four

Two new insurance plans have been added to broaden the range of ISMA sponsored plans. An Overhead Expense Plan and a Cash Value Life Insurance Plan brings the total number of supplemental insurance plans to four that are available to member physicians and professional corporations.

**new**

**OVERHEAD EXPENSE PLAN** provides needed dollars to help you pay off overhead expenses (employees' salaries, rent, utilities, property taxes, etc.) in the event of your disability. When disability strikes—your business overhead expenses keep right on going—even when you can't.

**new**

**CASH VALUE LIFE INSURANCE PLAN** provides permanent life insurance protection up to \$50,000 for those currently insured under the ISMA term plan. Accumulates attractive cash values. At age 65, policy becomes 50% paid-up with no further premium payments. All premiums returned in event of your death before age 65.

**INCOME PROTECTION PLAN** provides an income of up to \$1,500 a month if you are disabled and unable to work due to an accident or illness.

**FAMILY LIFE INSURANCE PLAN** provides benefits up to \$50,000 in the event of your death.

**ALL PLANS** are also available for professional corporations.

## COUPON

For information on the ISMA sponsored

- ☐ Overhead Expense Plan  
☐ Cash Value Life Insurance Plan

- ☐ Income Protection Plan  
☐ Family Life Insurance Plan

- ☐ Professional Corporation Plans

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Dr. \_\_\_\_\_

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Indiana State Medical Association  
3935 North Meridian Street  
Indianapolis, Indiana 46208

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# Deaths

## Stuart R. Combs, M.D.

Dr. Stuart R. Combs, 62, Terre Haute internist, died at Union Hospital, Terre Haute, on September 5.

He obtained his medical degree from the Indiana University School of Medicine in 1935 and interned at the Santa Barbara Cottage Hospital; he was later a resident at Vanderbilt University Hospital. Active in his state and county medical societies, Dr. Combs had served as Vigo County Medical Society president and as president of the Terre Haute Academy of Medicine and as chief of staff of Union Hospital. He was a member of the American Medical Association and a diplomate of the American Board of Internal Medicine and a Fellow of the American College of Physicians, the American College of Cardiology and the American Society of Internal Medicine. Dr. Combs served as a major in the U.S. Army Medical Corps in the European Theater from 1942 to 1945, receiving two battle stars.

## Phillip Todd Holland, M.D.

Dr. Phillip T. Holland, 68, who was a physician and surgeon in Bloomington for 38 years, died September 20 at the Bloomington Hospital.

He was a graduate of the Bellevue Hospital Medical College, New York, where he received his M.D. degree in 1931. He began practice in Bloomington as a partner of his father. During World War II he served with the Navy and was awarded the Asiatic Pacific Theatre medal with three combat stars.

A Councilor of the ISMA for many

years, he served twice as president of the Owen-Monroe County Medical Society and was a member of the American Medical Association, the Indiana Bone and Joint Club, American Association of Railway Surgeons and the International College of Surgeons.

## Wendell C. Kelly, M.D.

Dr. Wendell C. Kelly, Anderson, died July 30, 1973. He was 66.

A member of the staff of St. John's Hospital and the Community Hospital, Anderson, he was secretary of the medical staff of the former. Dr. Kelly was a graduate of the Indiana University School of Medicine and interned at the Indianapolis General Hospital. Called to active duty in 1941, Dr. Kelly served with the U. S. Army as medical officer of the 36th General Hospital and retired in 1945.

He was a member of the American Medical Association and the Madison County Medical Society.

## Gerald J. Kohne, M.D.

Dr. Gerald J. Kohne, 69, died September 4 at St. Joseph's Hospital, Fort Wayne. He had practiced in Decatur since 1932.

A registered pharmacist, he held medical licenses in Indiana, Illinois and Arizona. He was graduated from the School of Pharmacy, Notre Dame University, and Loyola University School of Medicine, Chicago, serving his internship at St. Elizabeth Hospital, Chicago.

He was a member of the American

Medical Association and the Adams County Medical Society.

## Charles Francis Leich, M.D.

Dr. Charles F. Leich, 66, Evansville otolaryngologist, died while attending a historical society meeting in Tell City on September 9.

He was a graduate of the Rush Medical School, interned at the Cook County Hospital and was a resident at the Illinois Eye and Ear Infirmary. During World War II he served as an officer of the United States Navy.

Dr. Leich was a member of the American College of Surgeons, American College of Otolaryngology and the American College of Ophthalmology. He was on the staff of St. Mary's, Protestant Deaconess and Welborn Baptist hospitals in Evansville and was also a member of the American Medical Association and the Vanderburgh County Medical Society.

## Francis C. Smith, M.D.

Dr. Francis C. Smith, Indianapolis, died September 14 at home. He was 76.

The first resident in the Department of Pediatrics at Riley Hospital, Dr. Smith was medical director for the Irvington Children's Guardian Home for 25 years. For the last 15 years he also served as medical director for the Lutheran Child Welfare Home.

A 1924 graduate of the University of Cincinnati Medical School, Dr. Smith interned at the Louisville City Hospital. He served in the Navy in World War II. He was a member of the American Medical Association and the Marion County Medical Society.

## INDIANA MEDICAL BUREAU

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# Association News

## EXECUTIVE COMMITTEE

Sat., September 8, 1973

The meeting was called to order by President James H. Gosman at 2:00 p.m. ROLL CALL: Donald M. Kerr, M.D., absent; Vincent J. Santare, M.D., James H. Gosman, M.D., Joe Dukes, M.D., Gilbert M. Wilhelmus, M.D., Hugh K. Thatcher, Jr., M.D., Arvine G. Popplewell, M.D., Frank B. Ramsey, M.D., and Mr. James A. Waggener, present. Guests present were members of the Executive Committee of the Indiana Hospital Association. They were Elton TeKolste, Harry Haver and Don Hamachek.

**DISCUSSION WITH HOSPITAL ASSOCIATION** — The Executive Committee entered into a discussion with the Hospital Association on special common problems: PSRO, criteria for staff privileges, criteria for treatment of various cases in the hospital, and other matters. There was no particular action taken on problems. The hospital representatives then left the meeting.

**MINUTES OF THE MEETING** held May 19, 1973, were approved on motion of Dr. Thatcher seconded by Dr. Wilhelmus. Membership report was approved by consent.

### HEADQUARTERS OFFICE:

The secretary reported on plans for the AMA meeting to be held in Anaheim, December 2-6, 1973. The matters of the Hospitality Room and Delegates Breakfast were deferred, pending a meeting later in the day with the AMA delegation.

**REPORT ON SALE OF EXHIBIT SPACE** — The secretary announced that 46 spaces had been sold to 41 companies for a total price of \$12,500. He also reported that Ciba, William S. Merrell Co., and A. H. Robins Company had each given a \$200 gift to the association rather than use exhibit space.

**TREASURER'S REPORT:** Dr. Thatcher reviewed the Financial Statement in detail showing budget comparisons with actual expenditures and reviewed the investment portfolio; his report was approved on motion of Dr. Thatcher seconded by Dr. Santare.

**MINUTES ON THE COMMISSION ON PUBLIC INFORMATION** — The

Commission on Public Information requested the approval of the expenditure of \$1,500 for the purpose of surveying the membership of the Association and bringing pertinent files up to date. The appropriation was approved upon motion of Dr. Thatcher, seconded by Dr. Wilhelmus. It was recommended to the Commission that the survey should be more comprehensive than the questions included in the sample.

**GOVERNOR'S CONFERENCE ON EMERGENCY MEDICAL SERVICES** — A letter was received from the Indiana Hospital Association listing the income and expenses of the recent Governor's Conference on Emergency Medical Services and showing that the ISMA pro rata share of the deficit was \$630.44. Upon motion of Dr. Thatcher seconded by Dr. Santare, this was approved for payment.

**A LETTER FROM THE INDIANA PUBLIC HEALTH ASSOCIATION** requesting a grant for the purpose of conducting a prelegislative study conference was turned down upon motion of Dr. Thatcher seconded by Dr. Santare.

**A LETTER FROM ISMA LEGAL COUNCIL** reported that the Appellate Court had upheld their pleadings in the Nicosia suit, in which the court ruled that in malpractice cases a minor is to be treated as an adult as to the statute of limitations for filing such suits. This means that unless a higher court reverses the Appellate Court decision, any malpractice action with regard to a minor must be filed within two years of the date of service. By consent, this report was referred to the Board of Trustees.

**LETTER TO THE GOVERNOR**, the secretary reported the proposed plans to move the Medical Board from the Board of Health Building to the old Burger Chef headquarters building on West Sixteenth Street and then read a letter which he had written to the Governor regarding opposition to this move before any definitive action is taken. The letter was approved by consent.

**A LETTER FROM JUDICIAL COUNCIL, AMA**, reporting on several matters that had been referred to the Council and seeking opinions of the various states was taken as a matter of information.

**AMA SECOND EDITION DRUG EVALUATION** — A letter offering the Association discount prices for distribut-

ing this book to the membership was taken as a matter of information.

**THE NATIONAL ACADEMY OF SCIENCES** request for the use of our membership list was approved by consent, providing the Academy is willing to pay the usual price for the list.

**A LETTER FROM THE WOMAN'S AUXILIARY** was read for the information of the Committee.

**THE MINUTES OF THE COMMISSION ON AGING** concerning the activities of a Raymond A. Burris, D.D.S., and his plans for a mobile dental unit to serve nursing home patients were reviewed and, by consent, it was agreed to write Dr. Burris commending him for his action, but the Association would not endorse this project.

**A LETTER FROM THE INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY** offering their cooperation in any PSRO Program developed by the Association was read for the information of the Committee.

**A LETTER FROM THE STATE BOARD OF HEALTH** in which they stated they had initiated action to change regulation HT6R and it should be effective by the first of October.

**A REPORT FROM THE AMA** outlining its policies regarding intern and resident memberships was referred, by consent, to the Board of Trustees.

**A LETTER FROM INDIANA HEALTH CAREERS, INC.**, seeking a financial contribution from the Association. Upon motion of Dr. Thatcher seconded by Dr. Dukes, \$50 is to be sent to this organization.

**A REQUEST FROM THE U.S. TREASURY DEPARTMENT** for the use of mailing lists was approved by consent.

**A LETTER FROM THE MARION COUNTY MEDICAL SOCIETY** seeking a legal opinion as to the appropriateness of some questions being asked physicians by hospitals was referred to the Board of Trustees by consent.

**A LETTER FROM MEDSERCO, INC.**, concerning their plans to start a chain of HMO Programs was referred to the Board of Trustees by consent.

**A REPORT BY W. A. BRENNAN, INC.**, regarding the building was reviewed and the secretary instructed to place this on the October agenda.



**A LETTER INVITING THE EXECUTIVE SECRETARY** to sponsor a People-to-People International Tour in 1974 was reviewed, with the secretary reporting that he felt he could not take the time to do this. He asked if any members of the Committee were interested. By consent, this information was referred to the Board of Trustees.

#### **CONVENTION MATTERS:**

A letter from Merck Sharp & Dohme offering a \$300 support grant to the Association in lieu of an exhibit. The acceptance of this amount was approved by consent.

A request from Dr. Ball, chairman of the ISMA Golf Tournament, for \$300 was approved on motion of Dr. Wilhelmus seconded by Dr. Thatcher. Dr. Ball is to be advised that the Association requests that the golfers do not have a separate lunch at Hillcrest and states that the golf awards would be presented at the dinner on Wednesday evening and the recipients must be present if they are to receive their award.

International Science and Engineering Fair — Upon motion of Dr. Wilhelmus seconded by Dr. Thatcher, Daniel Gallagher, Michigan City, Ind., is to be invited to bring his exhibit at ISMA expense to the Annual Meeting in October.

**BLUE CROSS-BLUE SHIELD MATTERS** — The Minutes of the Executive Committee of Blue Cross and the Minutes of the Joint Advisory Committee of Blue Cross-Blue Shield were reviewed for the information of the Committee.

**CORRESPONDENCE WITH THE STATE DEPARTMENT OF PUBLIC WELFARE** concerning certification and recertification was reviewed and the secretary was given permission to continue his efforts to get the certification and recertification of nursing home individuals handled on the same basis as has been used by hospitals in Medicaid and Medicare.

**A LETTER FROM A BEDFORD PHYSICIAN** concerning certification and recertification. The secretary was instructed to inform him that the Association is still pursuing this matter.

**JOURNAL MATTERS** — The Editor, Dr. Frank Ramsey, reported on the financial condition of *The Journal*. He also stated the outlook for increased advertising in 1974 was brighter and be-

lieved that income from advertising for next year would exceed 1973 income. He also reported that the survey conducted in July in Indiana showed that readership of *The Journal* ranked very high and exceeded that reported for *Medical Economics* in a recent similar survey. The percentage of Indiana readers was higher than that for *Medical Economics*.

#### **MEDICAL DEFENSE:**

A suit brought against an Indiana physician who has applied for medical defense and has submitted his attorney's fee schedule was approved upon motion of Dr. Thatcher seconded by Dr. Wilhelmus, with the secretary instructed to notify the physician that the funds for this were limited.

A letter from an attorney concerning his charges in a malpractice case was reviewed. The problem being that the physician had never informed the Association of a change in legal counsel. By consent, it was ruled that the attorney's charges were the sole responsibility of the physician.

The Secretary announced that he had been notified by another physician that he was threatened with a suit.

**NEW BUSINESS** — The Secretary read a request for the use of the mailing list of the Association for the purpose of notifying Indiana physicians of the opening of Community Hospital's new Comprehensive Rehabilitation Department. This was reviewed and the use of the list at the usual price was approved by consent.

**THE PRESIDENT READ A LETTER FROM THE INDIANA PSYCHIATRIC SOCIETY** regarding closer working relationships between their Society and the Association, especially in the fields of insurance and legislation.

**THE PRESIDENT READ A LETTER FROM THE INDIANA SOCIETY OF INTERNAL MEDICINE** concerning precertification and requesting ISMA to propose a resolution objecting to proposed precertification requirements as outlined in intermediary letters 73-10 and 73-12.

**THE PRESIDENT REPORTED** that there is to be held in Indianapolis a conference on prepaid health care and suggested that we might monitor this conference.

#### **FUTURE MEETINGS:**

Announcement that Regional Orientation Session on implementation of Sec. 221 of the Social Security Act would be in Chicago September 10-11. By consent, no representative will be sent.

An invitation from the Hospital Research and Educational Trust inviting a representative to attend a "Planning for the Planners" workshop to be held in Chicago September 18-19. No representative will be sent.

The AMA 14th National Conference on Physician and Schools to be held in Chicago 3-5. By consent no representative will attend.

The Governor's Twelfth Annual Conference on the Handicapped will be held in Indianapolis, October 3-5. It was recommended that Dr. James Kirtley be the Association's representative.

AMA Conference on Alcoholism, Washington, D.C., October 10-11. By consent, no representative will be sent.

By consent, the executive secretary is authorized to attend a meeting of the Medical Society Executives to be held in Chicago October 17-19.

By consent, the executive secretary was authorized to attend the Blue Shield Program Conference to be held in Chicago October 25-26.

A notice of the dates of meetings of the PSRO Council in Rockville, Md., was taken as a matter of information.

There being no further business, the Committee adjourned to meet again at 9:00 a.m., Sunday, October 7, 1973, in the Walnut Room of the Columbia Club.

#### **EXECUTIVE COMMITTEE AND THE AMA DELEGATION**

Sat., September 8, 1973

The Executive Committee met with the AMA Delegation at 6:00 p.m., in the Headquarters offices.

Roll call showed the following present: Dr. Gosman, Dr. Dukes, Dr. Wilhelmus, Dr. Senseny, Dr. Gardiner, Dr. Steen, Dr. Harshman, Dr. Walther, Dr. Neumann, Dr. Scamahorn, Dr. Montgomery and Dr. Corcoran.

The first item of business was a discussion of a resolution to be presented before the AMA House of Delegates at the clinical meeting in December 1973.



The resolution was approved for submission.

**Delegate Functions** — During the AMA Clinical Meeting it was agreed that the delegates would meet for breakfast at 7:00 a.m. on Monday, Tuesday and Wednesday mornings. The breakfast is to be continental style. It was agreed that the Hospitality Room would be open on Monday and Tuesday evenings from 6-8:00 p.m.

It was further agreed that, should Blue Shield invite the delegates to dinner, it should not be scheduled prior to 9:30 p.m. on Monday night.

It was decided no room favors would be given during the Clinical Meeting.

The secretary was instructed in the possibility of issuing patches of the Indiana State Seal which would adhere to the delegates' jackets.

The delegates indicated their preferences for attending the committee meetings

- Dr. Harshman — Reference Committee
- Dr. Scamahorn — Constitution and By Laws
- Dr. Senseny —
- Dr. Neumann — Insurance
- Dr. Corcoran — Medical Education
- Dr. Steen — Council on Medical Service

There being no further business, the meeting was adjourned.

BOARD OF TRUSTEES

September 9, 1973

The Board of Trustees was called to order at 9:00 a.m. on Sunday, September 9, 1973, in the Headquarters Building of the Association by Chairman Gilbert Wilhelmus.

Roll call showed the following:

Dist.	Trustee	
1	Gilbert Wilhelmus, Chairman	Present
2	Paul W. Holtzman	Present
3	Eli Goodman	Present
4	Howard C. Jackson	Present
5	Cleon M. Schauwecker	Present
6	Paul M. Inlow	Present
7	John O. Butler	Present
7	Joseph F. Ferrara	Present
8	Richard G. Ingram	Present
9	William M. Sholty	Present
10	Vincent J. Santare	Present
11	James A. Harshman	Present
12	William R. Clark	Present
13	G. Beach Gattman	Present

Dist.	Alternate	
1	Raymond L. Newnum	Absent
2	Betty J. Dukes	Absent
3	Thomas A. Neathamer	Present
4	William F. Blaisdell	Absent
5	William G. Bannon	Absent
6	Glen Ward Lee	Present
7	Donald C. McCallum	Present
7	John G. Pantzer	Present
8	Jack L. Alexander	Present
9	Max N. Hoffman	Present
10	Martin J. O'Neill	Present
11	Lloyd L. Hill	Absent
12	Walter D. Greist	Absent
13	Donald S. Chamberlain	Present

Officers		
James H. Gosman	Present	
Joe Dukes	Present	
Hugh K. Thatcher, Jr.	Present	
Arvine G. Popplewell	Present	
Frank B. Ramsey	Present	

Executive Committee		
Donald M. Kerr	Absent	
Vincent J. Santare	Present	

AMA Delegates and Alternates		
James A. Harshman	Present	
Eugene F. Senseny	Absent	
Malcolm O. Scamahorn	Absent	
Lowell H. Steen	Absent	
Jack E. Shields	Present	
A. Alan Fischer	Absent	
Ross L. Egger	Absent	
Kenneth O. Neumann	Present	
Thomas C. Tyrrell	Present	
Patrick J. V. Corcoran	Present	

Guests		
Glenn W. Irwin, Jr.	Present	
Sprague H. Gardiner	Present	
George Lukemeyer	Present	
James C. Herod	Present	
Richard C. Kilborn	Present	
Joe M. Black	Present	
Shell Robinson	Present	

Staff		
Robert Amick	Present	
Howard Grindstaff	Present	
Michael H. McDermott	Present	
Kenneth W. Bush	Present	
James A. Waggener	Present	

REPORT OF CHANCELLOR IRWIN

Dr. Irwin gave the Board an explanation of Indiana University—Purdue

University, Indianapolis, citing the fact that this complex is a major division of Indiana University even though the name Purdue is in the school's title. He said that from an organizational standpoint it is still Indiana University and the chancellor reports to the president of Indiana University. Purdue, he said, plays a very important role in the organization with its academic mission, in areas of engineering, the sciences, agriculture, and so on. IU-PUI consists of 12 different schools, Dr. Irwin reported, but did not go into detail on these. He said that the budget for IU-PUI is \$90,000,000 this year with the School of Medicine and its university hospitals responsible for \$65,000,000 of that budget. He said he is enthusiastic about his role as chancellor because he still will be involved in medical and health affairs and that the dean of the School of Medicine reports to the chancellor.

Dr. Irwin pointed out that the school unanimously recommended Dr. George Lukemeyer for the post of acting dean. Dr. Irwin further stated that the president of the university will appoint a search committee involving representation from the Indiana State Medical Association and he said he is rather certain the following people will be appointed—Dr. James Gosman, Dr. Joe Dukes and Dr. Patrick J. V. Corcoran. In addition, Dr. J. O. Ritchie will serve on this search committee with two medical students and probably the deans of the School of Dentistry and Nursing.

REPORT OF DR. GEORGE LUKEMEYER

Dr. Lukemeyer reported to the Board that he met with all department chairmen and it was his intent to make the transition for the next dean as smooth as possible. Dr. Lukemeyer went over high-light statistics for the new medical school class, stating that there were approximately 1,700 applicants, among which there were 853 Indiana resident applicants. He said 295 Indiana residents were accepted and 10 non-residents. The distribution, he said, is 253 males and 52 females. He also explained the scores in the medical college admission tests which were outstanding. Dr. Lukemeyer circulated information to the Board on the distribution of students by their county of residence.

He also urged the Board to read the information sheet which is sent to every medical school applicant and which reviews the admission committee's policy



and procedure. This form was prepared because of many questions raised concerning medical school admissions over the years. Dr. Lukemeyer said that Dr. J. O. Ritchie would chair the Admissions Committee for 1974 which would be composed of 31 members of the faculty, a good proportion of which are members of the Indiana State Medical Association, are members of the House of Delegates and are holding responsible positions in many cases with local medical societies.

#### REPORT OF DR. K. O. NEUMANN

Dr. Neumann reported that he had made a trip to Florida to study a mechanism for the State Association to actively participate in the establishment of an insurance program initially limited to malpractice, or professional liability, and later potentially expanding into other areas of insurance.

He pointed out to the Board that, should they decide to proceed with the concept, it would be necessary to establish a for-profit corporation with the Indiana State Medical Association, an Indiana medical corporation, holding the stock and entering into an arrangement with a major carrier to provide the service. He further pointed out that since study on this matter had been initiated, another major carrier has shown interest. He said that his Commission on Medical Economics and Insurance is asking the opinion of the Board concerning the advisability of pursuing the matter further.

Dr. Neumann said that the carrier would desire a survey made of the membership to determine interest in participating in this program. Initially in Florida a great volume of participation was not accomplished but it rapidly snowballed after the physicians became acquainted with the service being offered. Dr. Neumann advised that the legal technicalities would have to be reviewed very carefully with the attorneys concerning tax structure, implications and any other problems which might arise under Indiana law.

*Following considerable discussion on the matter, it was moved by Dr. Gattman to continue further study and investigation by the commission. This was seconded by many. Dr. Thatcher inserted that the commission be empowered to go to attorneys to search the law. The Chair said this would be taken by consent and the motion carried.*

#### REPORT ON CRITERIA FOR DIAGNOSIS AND TREATMENT

Dr. Neumann then discussed the point that groups of physicians and/or committees in hospitals are attempting to establish criteria for diagnosis and treatment of medical conditions such as malignancies, hypertension, coronary care, kidney disease, pulmonary disease and so on. He said that some feel this is an educational program and affirmed that there was certainly nothing wrong with an educational program, but when these same criteria are then established and adopted by the medical sections, and subsequently approved by the staff as a whole, these could become criteria for medical care in that particular area. He said that it would seem feasible to get an opinion of the ISMA attorneys as to whether or not this could create problems for physicians. A legal situation could be created if a physician does not follow the criteria. He could very possibly be guilty of some type of negligence or malpractice, Dr. Neumann said, and reiterated that he felt that an opinion was necessary for the protection of physicians.

Chairman Wilhelmus asked for a discussion on the issue.

Pros and cons of asking for a legal opinion were debated. Dr. Neumann added that, unfortunately, hospitals have an opinion through their attorneys which states that there is no situation created by these criteria which would be harmful to physicians in their practice.

Dr. Thatcher said he felt that if the ISMA had an opinion at this time, there would be some interesting negotiations at the Indiana hospital level. He said that he felt that such an opinion should be given to the Indiana Hospital Association and he expressed the thought that their leaders would accept the opinion. He thought it would be a dollar well spent at this time rather than to wait and be compelled later to take the matter to court.

*Dr. Harshman moved that the Board approve the expenditure of monies for attorneys to investigate the situation which had been outlined by Dr. Neumann. The motion was seconded by Dr. Thatcher.*

*Dr. Gosman moved to amend the motion to the effect that ISMA immediately inform the physicians in the state of Indiana to cease and desist in this matter until some final conclusion could be achieved. The amendment to the motion was seconded by Dr. Schauwecker.*

Chairman Wilhelmus called for a vote on the amendment and it passed, and the vote on the original motion, as amended, was passed with one dissenting vote.

#### REPORT OF DR. CORCORAN

Dr. Corcoran reported that he had spent two days in Chicago meeting on the subject of health manpower and pointed out that the Council on Health Manpower is now preparing for a second Congress on Health Manpower to be held in about a year which would generate information and develop data on a number of items of current importance.

He said that there was concern expressed by many that there is an overproduction of physicians and that some time between 1977 and 1980 physicians would be in the same position as teachers and some scientists.

He also pointed out that there would be some analysis of the quality as well as the numerical quantity of physicians.

He discussed statistical data on foreign medical graduates and their numbers as compared to American graduates practicing in the United States.

He said that a good look would be given at the physician assistant and nurses and he said that more and more attention is being focused on the point that nurse assistants would be a dominant, or a major group, in this allied health field. There would be more and more attention to emergency services concerning transportation and communication as well as distribution of medical care and health care services for sparsely populated areas.

He discussed the rewards of continuing medical education for the practicing physician and said that in some states continuing medical education is required for membership in their associations. He said that the next step beyond this is recertification. He said that certification has prestige value because it enables the individual to charge a greater fee for service and he was told that in the implementation of Medicare and Medicaid and other governmental programs and other third-party payments it is now a fact that a certified physician does get a preferential payment. He said the real threat in relicensure is that this can impede an individual's ability to practice. Three states now have this already enacted—Kansas, New Mexico, and Maryland.

Dr. Corcoran said that AMA Council will submit to the Board of Trustees at their clinical meeting in December a



recommendation that the AMA continue to hold to its policy that what the physician does and what he knows are significant considerations, and that the accumulation of data, experience, and information on this be approved or disapproved, and that objective data on the impact of continuing medical education upon competence of professional ability also be accumulated.

Additionally, Dr. Corcoran said the Council on Health Manpower will recommend that legislators and Boards of Licensure be advised of the importance of continuing education and the evaluation of performance and peer review; that they be further advised that these matters are under very active study; that the Association has reservations about how these should be utilized; and that vigorous efforts be made to prevent or forestall any legislation in this area.

Chairman Wilhelmus then asked Dr. Lukemeyer if he thought the need for a sufficient number of physicians would be met.

Dr. Lukemeyer replied, "I don't think there is an answer to your question; and this you already know, and that is the number of physicians for 100,000 population is greater than it was a number of years ago; and the number of students who have been accepted by the medical schools and have graduated have far exceeded the rate of growth of the population—regionally and locally." He said we have the problem of more physicians than we used to have in ratio to population but the number of people providing primary care is decreasing.

## BLUE CROSS PRESIDENT'S REPORT

Mr. Herod reported that the program that he had discussed with the Board of Trustees at a previous meeting had been set in motion and that Blue Cross was working in two counties where they had total cooperation and that the program as designed would be explained and developed statewide hopefully before the end of the year. He said the key to the program was cooperation at the local level and this was being achieved. It was his hope that the program could be worked out rapidly.

He said that since the operations of Blue Cross and Blue Shield were integrated, the organization was in a better position now to make this type of program work. He said that with the integration of operations that there had been a dramatic reduction in the operating costs of Blue Cross and Blue Shield.

At this point in time, he said, there is about a \$6 million reduction over previous costs. Operating costs were about 9%, he said, and we are now down to 6%, he said, and if we can continue at the present pace, we would hope, by the end of our fiscal year, that our operating costs will probably be in the 5% area. These are joint operating costs, not just Blue Shield, he pointed out.

At one time, he said, Blue Cross operations were about 5%; Blue Shield's would have been about 7 or 8%. Naturally, he pointed out, Blue Shield is always higher than Blue Cross because they have about three or four Blue Shield claims to one Blue Cross claim, and that accounts for most of the difference.

Mr. Herod reported that more joint committees were very active and cited the activities of the Joint Medical Advisory Committee, the Budget Planning Committee and the Joint Operations Committee.

He said that at this point in time, Blue Cross/Blue Shield has 49,000 new members. Last year concluded with 27,000 new members, so that in the sales areas there has been a great boost. He stated that further cost reductions are being planned through crosstraining of all employees who operate in both the Blue Cross and Blue Shield programs.

Mr. Herod then reported on Medicare certification and recertification requirements and pointed out that he had talked to President Gosman just prior to the meeting and that it was his suggestion that Blue Cross/Blue Shield, the Hospital Association, and the ISMA meet to develop a form that would be satisfactory for everybody to use in the recertification program. He said Blue Cross would welcome the opportunity to meet with these groups to work toward this end.

Explaining the regulation on certification and recertification, he said the following information was needed: (A) The medical necessity for admission, (B) Prognosis, (C) Plans for post-hospital care, if needed, and (D) The date and signature. He pointed out that recording on the preceding information could be accomplished in three ways. (1) A rubber stamp stating that information is contained within the medical record and is in fact documented. (2) A commercial form containing specific questions and answers. (3) A form developed by the institution and providing the same information. He said that hospital physicians could use any form they wish, provided it carries this basic information and

providing it has the signature of a physician on it. These rules, he said, apply to Medicare, Medicaid, and all federal employees.

Dr. Shields asked Mr. Herod if Blue Cross/Blue Shield pays for abortions: the hospital, and the surgeon. Mr. Herod replied the insurance program pays for all abortions provided they have maternity coverage.

Dr. Holtzman asked what would happen if the doctor would not sign the recertification form. Mr. Herod replied that the bill would not be paid.

Dr. Goodman inquired about periodic recertification. Mr. Herod replied there has to be certification on admission. The next certification has to be on the twelfth day, the next certification by the eighteenth day, and the next certification can be delayed but for not more than 30 days.

Dr. Gosman asked Mr. Herod how they were proceeding with plans for outpatient claims. Mr. Herod replied that they are experimenting with this in two counties.

Mr. Herod was then asked if he would be interested in considering medical liability insurance with the Indiana State Medical Association. Mr. Herod replied that at this point he had not given this any consideration. The only activities that they are currently becoming involved in is through a separate corporation in which they will be dealing with a life insurance company and will be providing benefits for their hospitalization customers. He said their salesmen would sell; that Blue Cross will not underwrite the life insurance policies.

Dr. Schauwecker then asked Mr. Herod what the current thinking of Blue Cross/Blue Shield was concerning a hospital built and developed by a corporation for profit. He pointed out his county had been approached by a firm that wishes to build a for-profit hospital and that he understood Blue Cross/Blue Shield strongly opposes this type of operation and that there are none in Indiana.

Mr. Herod replied that there are none in Indiana; at one time there were three or four. Blue Cross established a policy that they would not contract with a for-profit hospital.

Dr. Schauwecker replied that that would mean that if a company built a hospital in Indiana, those patients covered by Blue Cross/Blue Shield would probably not use the institution inasmuch as insurance would be no good.



Dr. Goodman asked Mr. Herod to illuminate the Board a little as to why Blue Cross has this attitude toward a for-profit hospital, since some of the hospitals in the Kentucky area are excellent in their operations.

Mr. Herod replied that he had heard that there are some good operations but he had also heard that there are some which are not so good. He said that your for-profit hospitals render those services which can guarantee them a profit and that if a service is not profitable to the hospital, the hospital will eliminate it. If the outpatient department is a problem, they will do away with such service. He said most of them are not full-service hospitals and that the events which prompted the action of the Blue Cross Board some 10 years ago was because for-profit hospitals in the Chicago area were spilling over into Indiana zones and being run by organized underworld elements on a for-profit basis, giving many problems to the Illinois Plan. Finally, the Illinois Plan refused to reimburse these for-profit hospitals.

Dr. Butler then inquired of Mr. Herod as to an emergency clause in a contract that if a patient is injured and carried to a non-participating hospital, he will be covered. Mr. Herod replied that it could be in some of the contracts and that in the negotiated contracts that he was sure that this would be covered.

## REPORT ON ABORTIONS

Dr. Gosman reported that a problem with which the Indiana State Medical Association is currently being confronted concerns institutions wanting to set aside a room to do abortions and which are currently attempting to contract with hospitals to transport a patient to a hospital should they run into complications during the procedure. Dr. Gosman said the law states that abortions can only be done in hospitals that have been approved by the Indiana State Board of Health. Dr. Gosman asked Dr. Hugh Thatcher to comment on this situation.

Dr. Thatcher said that Dr. Gosman had called upon him because of his membership on the Hospital Licensing Council for the state of Indiana. He said the law states that in the first trimester on the desire or the consent of the physician to do an abortion, this procedure may be performed in a duly licensed hospital or health facility. He said, however, that regulations had not yet been promulgated which would delineate the fine points in the framework of the law.

At the present time, he pointed out, the state, so far as he knew, had no way of controlling the carrying out of abortions in a nursing home which is licensed by a different commission.

Dr. Thatcher said also that the surgicenter has to be considered, too, and they fall under a different part of a different enrolled act in regard to performances or procedures, but they do come under review of the Hospital Licensing Council to decide whether or not they can be licensed. He said that when you get into this particular area you do have some control since the law stipulates, and the regulations, once they are promulgated in regard to the surgicenter, will exercise better control over their operations.

He said they had met with the Fire Marshal's office, the engineering department and other departments on the proposed regulations and that these regulations will be sent back to the Council by November and if everyone is still in agreement, they will then be sent to the executive committee of the State Board of Health. Once they are agreed upon, they will become regulations.

Mr. Waggener commented that there have been several court decisions in other states confirming a doctor can do an abortion in his office even though the law says it has to be done in a licensed hospital.

## REPORT OF DR. SPRAGUE GARDINER

Dr. Gardiner told the Board that several years ago the Board of Trustees created the Ad Hoc Committee on Maternal and Child Care to study the improved care of mothers and newborns within the state and to study the possibility of regionalization for the care of these mothers and newborns. He stated that the committee is made up of individuals representing obstetrics, gynecology, pediatrics, family practice and public health.

He said his committee had been working hard and he wished to give a report to the Board of Trustees and asked Dr. Edward Gresham to make a few comments on the progress of the committee's activities.

Dr. Gresham said that a year ago the prenatal center was initiated at Indiana University with the opening of Riley Hospital's special care nursery. The goals of this nursery, he said, were to provide comprehensive care for the critically ill newborn infant and described it

as being able to provide most any type of care which would be required for any situation that might arise in the prenatal period.

He also pointed out that the center would be a prototype for the development of other centers and certainly is a center where people could be educated and where ongoing research could afford a way for changes in the future.

Dr. Gresham explained statistics on the number of newborns medically treated, etc., and went on to say that in an effort to develop greater impact on a statewide basis the center set up a prenatal "hot line." This hot line provides rapid telephone consultation service and is available day or night for physicians involved in obstetrics and pediatrics who are dealing with newborn infants.

He said the program of calling in for consultation had been enthusiastically received by nurses, physicians and hospitals throughout the state and they are currently receiving about 10 calls a day for consultation.

Sometimes, he said, a consultation results in a transfer of a patient from one hospital to another.

He described a 75-mile radius around the Indianapolis area to which transport teams are sent and they are capable of reaching almost any hospital within that radius within less than an hour and a half of the time of the call. These teams evaluate the baby, decide whether the baby needs to come to the center, and if so, stabilize and travel with the infant.

Outside of the area of 75 miles, the committee has developed a transport system with the transport service of the State Police. They found that they were able to move into the local hospitals for certain problems by helicopter. The transport team is presently picking up 350 babies a year. Last month they brought in 36. The team has visited approximately 50% of the state hospitals' obstetrics services and this is important, he said, because it is giving them the opportunity to do an evaluation, on location, of the technical skills available. He said unfortunately he has found that many of the hospitals do not meet the proposed standards of the American College of Obstetrics and Gynecology and the American Academy of Pediatrics.

Dr. Gardiner then called on Dr. Baum to report on the Methodist Hospital program as part of the committee activity. Dr. Baum stated that the community hospital and the private nurse are going to have to play a very important role in this program. He said that in the state less than 10% of the babies are de-



livered either at Methodist or the Indiana University Medical Center.

He described the activity at Methodist Hospital and cited the hospital as not a typical hospital, since they are the largest hospital in the state. He said the Methodist delivers close to 4,000 babies a year and they have about 600 babies a year passing through their special care units. The hospital also has a house staff of 117 physicians.

It was pointed out, however, that Methodist is a practitioner's hospital devoted to the private practice of medicine and pointed out that, with rare exception, most of the babies seen in the hospital have been delivered by private practitioners and will be taken care of at the receiving end by the practitioner.

Pertaining to private practice, Dr. Baum said that Methodist is very heavily involved in the training of men who are going into private practice. The family practice program at Methodist is now the largest in the United States. They have 24 general practitioners, 8 of whom are each year spending at least one month in the special care unit.

He said these are the same physicians who are going into Paoli and elsewhere. He also pointed out that Methodist also has a hot line which can be reached by dialing the letters NEWBORN. Dr. Baum went on to elaborate further on the extent of their service, their transport team operation.

Dr. Gardiner closed the comments by pointing out that this is an Indiana State Medical Association activity and he thanked the Board for permitting them to continue on in this very valuable work.

#### **REPORT OF THE BUILDING COMMITTEE**

Dr. Hugh Thatcher referred to the report which had been circulated to the Board of Trustees and which had been formulated by Brennan Associates in Indianapolis. The report gave an in-depth study. Dr. Thatcher pointed out that their (Brennan) feeling at the present time is that the present facility offers a great deal and that by adding 5,000 square feet the cost would be approximately \$150,000. He went into additional detail on the alternatives in purchasing new ground and constructing a new building. He asked permission of the Board to hold a committee meeting with the objective of reporting to the Board at the next meeting in October, at which time the Board would be able to make their own decision as to where to

proceed from here. The suggestion was taken as a motion, was seconded, and passed.

#### **REPORT OF THE BOARD COMMITTEE ON ECONOMIC AND FISCAL MATTERS**

Dr. Goodman reported that the request for \$20,000 a year had been referred to the committee by the Commission on Public Information. Dr. Goodman said that it had been suggested that this Board recommend to the House of Delegates that the House ask for a \$5 dues increase for a special assessment each year for a period of two years in order to finance the commission's proposal, at which time the matter would then be referred back to the House for additional consideration. He said he felt that such a time period would provide adequate testing for the effectiveness of such a program and moved that this suggestion be adopted by the Board and referred to the House. The motion was seconded and was passed.

#### **REPORT OF THE EDITOR OF THE JOURNAL**

Dr. Frank Ramsey gave a report on the financial aspects of THE JOURNAL's operation and pointed out to the Board that THE JOURNAL of ISMA had been the subject of an advertising readership survey which was conducted by including a valid check for \$5 to the addressee which was inserted in every 40th copy of the publication mailed.

The advertising readership, he said, is judged by the number of \$5 checks which are cashed. This was done deliberately in July because the summer months are thought in the advertising business to be the dull months. Everyone has thought that no physician ever looked at a journal in the summer, especially during the months of June, July, and August.

Medical Economics last winter did this check and was very proud of its 31% return. He said the Indiana State Medical Association Journal had registered a 38% return and pointed out that this was like beating California in the Rose Bowl.

#### **REPORT OF THE TREASURER**

Dr. Thatcher made a report of the financial status of the Indiana State Medical Association and moved the report be accepted. It was seconded by many and passed.

#### **REPORT ON TEL-MED**

Dr. Thatcher reported that the Association had not gone into any additional expense—that the telephone expense has remained constant on a monthly basis. Mr. Waggener pointed out that Tel-Med is still operating in the black.

#### **DISTRICT REPORTS**

1st District—No Report

2nd District—Dr. Holtzman asked for remission of dues for a physician in his district. *The motion was made to remit the physician's dues and it passed.*

3rd District—No Report

4th District—No Report

5th District—No Report

6th District—No Report

7th District—No Report

8th District—Dr. Ingram moved for remission of dues for a physician in his district and the Board passed the motion.

9th District—No Report

10th District — Dr. Santare reported that they held their district meeting September 10 at the Lake of the Four Seasons and elected Dr. Mansueto president and Dr. James Brown secretary. Commenting on the activities of the 10th District, Dr. Gosman said that at this particular meeting the district did something which he thought was excellent and suggested it to the other districts for their utilization. Every member of the district who is a member of a committee or commission of the Indiana State Medical Association gave a report of that committee or commission's activities.

11th District — Dr. Harshman reported that the district meeting would be held on September 19 at Marion. He said it would be a festive occasion since the district would be celebrating the 125th anniversary of the Howard County Medical Society. Dr. Tom Nesbitt, speaker of the AMA House of Delegates, would be the guest speaker.

12th District — Dr. Clark extended invitations to all of the trustees to attend the forthcoming meeting of his district to be held on Thursday following this meeting of the Board of Trustees.

13th District — Dr. Gattman reported that his district meeting would be held on Wednesday, September 10, and they would also have their commission members speak. Gov. Otis Bowen would be the speaker of the evening.



## REPORT OF THE BLUE SHIELD PRESIDENT

Mr. Kilborn reported to the Board that it had been a good year. The membership of Indiana Blue Cross/Blue Shield is 40,000 members, an increase over a year ago. He said the organization now stands at 8,000,000 people. He also pointed out that he understood unofficially that Blue Shield had obtained a very important account, the account of the state employees. Mr. Kilborn commented on the advertising and publicity campaign which is being conducted concerning Blue Cross/Blue Shield. Some have commented on the bad taste of such a campaign but other Board members said it was one of the smartest advertising campaigns that the Blues had ever initiated. He said that the Blue Cross/Blue Shield Boards see national health insurance at least three years away and that their best intelligence tells them that when something does come out of Congress, it will probably be a middle-of-the-road bill supported by Wilbur Mills.

Mr. Kilborn then discussed the Iowa PSRO plan and stated that first they developed parameters based on available medical statistics to be used by the plans for their claims screening and review mechanisms. In other words, he said, the Foundation PSRO decides what parameters are going to be considered totally acceptable. Anything beyond the parameters goes back to the society for review. This, he said, does not mean they will not be paid. He said it just means that the computer rejects these and they are simply subject to review by the PSRO. Second, they have developed procedures and norms of health care. Third, they periodically review and revise such norms, guidelines and criteria. Fourth, they provide peer review for claims referred by Blue Cross/Blue Shield and this is for Medicare and Medicaid and regular business. Fifth, they render a decision for each claim and report this decision to the plan; and, last, they consult with and advise, assist, direct and plan concerning the establishment of operation of provider review committees and the evaluation of plans and claims review processes.

Blue Cross and Blue Shield, on the other hand, Mr. Kilborn reported, have the following responsibilities: First, they recognize the Foundation as their medical consultation advisor. Secondly, they operate claims review and screening mechanisms utilizing parameters provided by the Foundation. Next, they forward

all claims failing the standards of medical necessity to the PSRO; and, last, they accumulate and assimilate to the Foundation claims and other health data.

Mr. Kilborn pointed out that in his opinion these are the responsibilities of medicine vs. the responsibilities of the carrier and said that obviously medicine controls the data and he expressed the point of view that he thought this was extremely important—that medicine should control the data.

The Board asked Mr. Kilborn many questions concerning the operation of Blue Cross and Blue Shield and their operations under Medicare and Medicaid.

## REPORT OF DR. BLACK, CHAIRMAN OF THE BLUE SHIELD BOARD

Dr. Black reported that Blue Cross and Blue Shield had made a decision to become involved in life insurance. The Board had to examine their charter and in their charter they found a deficiency concerning a minimum and maximum number of directors. Following this examination there had been some confusion, he said, about the number of directors on Blue Shield. He pointed out that the present number of directors on Blue Shield is 25 and that the bylaws will be changed and will require a 66 2/3s vote of the members of the Board to change any membership on the Blue Shield Board. He said he believed this would build in adequate responsibility in the medical profession.

## REPORT OF THE PRESIDENT

Dr. Gosman outlined in detail the activities planned for the state convention. In the course of his report, Dr. Gosman said he arranged with Dr. Crane of the Public Information Commission to have a speaker appear before the House of Delegates to deliver a talk to demonstrate the type of person Dr. Crane was thinking of in developing his public information project and to give some insight into the plans for the Association.

Dr. Ingram asked Dr. Gosman the name of the individual who was to speak against PSRO during the House of Delegates meeting. Dr. Gosman told him that Dr. Carter, editor of *Family Practice* magazine, would be this speaker.

Dr. Gosman asked for approval of the Board to pay expenses and travel for Dr. Crane's speaker. **The motion was made to approve and it passed.**

## REPORT OF PRESIDENT-ELECT

Dr. Dukes reported that he was about to complete the membership appointments to the commissions and committees and asked the Board for names of individuals who wished to serve on commissions and committees. Dr. Dukes also advised the Board of several meetings he was planning to attend in the near future concerning the affairs of the Association.

## MINUTES OF THE JUNE 17 BOARD MEETING

**Dr. Harshman moved that the minutes be accepted. They were seconded and the motion carried.**

## MATTERS REFERRED BY EXECUTIVE COMMITTEE

1. People to People International proposal for an M.D. to escort a group overseas was read for the Board's information.

2. Letter from Med-Serco, Inc. was read. This is an outside organization attempting to come into the state to induce Indiana doctors to become members.

3. Letter received from Dr. Howard, AMA, concerning interns and residents.

4. Medical Defense Opinion received from the Court of Appeals that minors are to be treated similarly to adults for malpractice cases. The Chair suggested that this information be put in a Newsletter.

MEDICARE PAYMENT GUIDELINES that Blue Shield submitted was suggested by Dr. Santare to be sent to the trustees.

BOARD LIAISON COMMITTEE WITH BLUE CROSS. Dr. Harshman said the outpatient surgery program will start October 1 in the counties of Howard, Grant, Tippecanoe, Vigo, Bartholomew and Monroe and will run for six months. This outpatient program will pay for surgery procedure in the doctor's office and for supplies used. It will be experimental for six months.

## REPORT OF DR. CHAMBERLAIN

Dr. Chamberlain referred to a resolution which he had circulated to the Board concerning a change in the bylaws. Dr. Chamberlain pointed out that there was a physician in his area who had retired early, was financially in excellent condition, does not have too much to occupy his time, but would like to remain active in the work of the county society.



Basically, Dr. Chamberlain said, the resolution asks that he not have to pay full dues since he is retired from the practice of medicine. Dr. Chamberlain expressed the feeling that this type of man has a role to play in medical society activities in a number of ways. He said that this physician wants to be an active member of the society and is willing to be but feels that this would be an appropriate measure from the State Medical Association since many of the benefits he now receives from the Association do not apply to retired members. **After a discussion of Dr. Chamberlain's proposal, Dr. Thatcher moved that the Board accept this as a Board recommendation. The motion was seconded and passed.**

#### REPORT OF THE AMA DELEGATION

Dr. Harshman reported to the Board that the AMA Delegation had met in the headquarters office the previous evening. He reported to the Board that the delegation would like to introduce a resolu-

tion to the AMA and referred to the copy which had been circulated to the Board. Dr. Harshman reported that at the New York meeting, the Council on Long-Range Planning and Development had made a recommendation that the House of Delegates be increased by roughly 49 members by accepting into the House of Delegates representatives from specialty societies. He said this is in addition to the 26 section delegates now currently in the House and said that this would, in effect, dilute the House of Delegates. Dr. Harshman said it was the feeling of the delegation that specialty societies would dominate the AMA if such a recommendation were allowed to pass the AMA House of Delegates.

Basically the delegation wishes to ask that the Council on Long-Range Planning's New York report be filed and that the House rescind its previous referral. **He then moved that the Indiana State Medical Association introduce this resolution at the clinical session in December, 1973. The motion was seconded and passed.**

#### RESIGNATION OF AMA DELEGATE

Dr. Jack Shields, AMA delegate, circulated a letter to the Board of Trustees advising them that he would not seek reelection as an AMA delegate.

#### APPRECIATION GIFT

Dr. Gosman expressed his appreciation of the cooperation of the trustees by presenting each with a briefcase printed with the ISMA logo and their initials.

#### FUTURE MEETINGS

The Board will meet on October 7, 12 noon luncheon, at the Columbia Club, Parlors B and C, and on Tuesday, October 9, at 8:00 a.m. for breakfast at the Convention Center, Room 210. The Board of Trustees' Annual Dinner will be \$20 a person at the Columbia Club, 8:00 p.m., on Sunday, October 7.

During the course of this meeting, the Board went into executive session.

The meeting adjourned at 6:00 p.m.

## From The Journal 50 Years Ago

The thymus has for many years excited the interest of clinicians and investigators. For nearly a century the literature has been filled with discussions concerning the anatomy, physiology and pathology of the gland. More recently the discussion has been revived on account of the gland having been found hypertrophied in Basedow disease or exophthalmic goiter.

It is with this point in view that I have reviewed the literature and at the same time report my observations from a study of 288 cases of toxic and non-toxic goiters that came to autopsy at the Mayo Clinic from 1914 to 1922, with a typical case report illustrating the role that the hyperplastic thymus may play in some instances.

The association of an enlarged thymus with Graves' disease was first described by Markham in 1858. Soon after Mobius, Weigert, Spencer and other recorded similar observations, but they all interpreted it as casual coincidence. Schitzler in 1894 was the first to attach any importance to these observations. He reported a similar case and pointed out that in all probability the hyperplastic thymus was responsible for the death. Bonnet in 1899 reviewed the literature and collected 28 post-operative cases of exophthalmic goiter that died soon after operation and had associated a persistent hyperplastic thymus. Similar reports were soon made by Hansemann, Gierke, Monkelberg and others. Finally Capelle in 1908 placed the question within the surgical field by reporting a series of 60 necropsies performed on patients that had died with Basedow disease . . . Hart in 1908 suggested that the abnormal activity of the thymus might be responsible for a clinical picture similar to that of Basedow disease. This conclusion was based upon the observation at necropsy of a man with symptoms of Basedow disease in whom there was found an abnormally large thymus while the thyroid gland showed no gross or microscopic pathologic changes. The thymus of this individual when transplanted into the peritoneal cavity of guinea pigs proved to be extremely toxic, while a similar transplantation of a calf thymus gave rise to no symptoms. Thus he concluded that in a persisting thymus are stored toxic substances which enter the blood as an internal secretion and give rise to symptoms similar to those associated with hyperplastic thyroid gland . . . Alfred S. Giordano, M.D., South Bend, "The Frequency of Thymic Hyperplasia in Toxic and Non-Toxic Goiters," JISMA, Nov. 1923.



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# The JOURNAL



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**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

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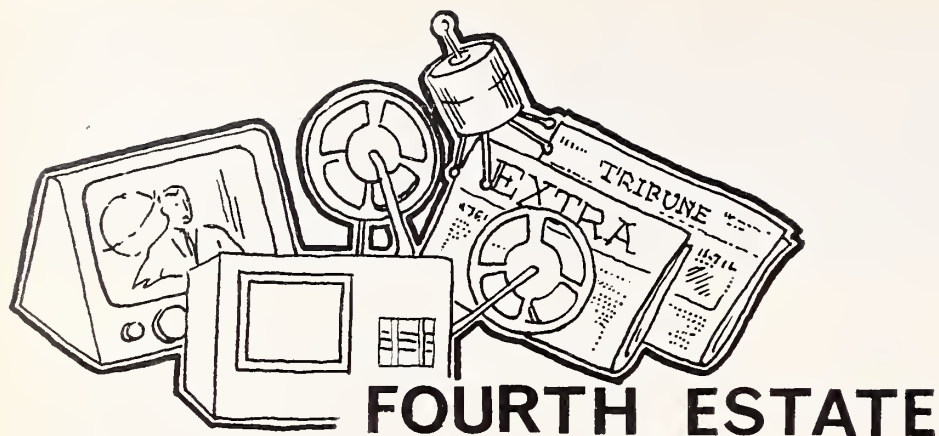


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This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

## Way of Death

On Oct. 12, the board of the County Health and Hospital Corp. is to rule on a proposal that the obstetrics service at General Hospital be abolished in order to release funds for a proposed abortion unit. The unit is expected to perform approximately 6,500 abortions annually.

This strange proposal is being made on the grounds that offering abortion services is required by law (suggesting obstetrics isn't) and that the board has no options. The board's attorney says this macabre situation springs from the U.S. Supreme Court decision which made abortion legal—even for non-medical reasons—and that a publicly financed institution cannot legally refuse to provide facilities.

The argument is absurd on its face since the U.S. Supreme Court ruling certainly did not make abortions more legal than giving birth. Asked why the hospital is not equally obliged to retain obstetrics services, the attorney explained that the board did not ask him about that so he hadn't advised them. And he would not discuss it with anyone else.

There are at least two explanations for this outrageous proposal that appear more plausible than mere compliance with the law. The first is the existence of numerous pro-abortion pressure groups. Such

organizations are more than eager to go to court to make abortions easily available to anyone that desires one, even for the most whimsical of motives. Another is the familiar tactic among public agencies of eliminating a popular and badly needed function in order to extract the funds needed for less palatable activities.

It is probably true that a public institution cannot refuse to provide a medical service that is legal, but it can demand that some medical purpose be served by it. Public funds should not be spent for mere cosmetic or convenience operations. Furthermore, if the budget does not permit unlimited abortions and *acceptable obstetrics* then the board should determine which shall take precedence and obviously life should have priority over death, not the other way around.

Arthur Owens, director of the corporation, commented that the law requires the hospital to provide a service to the indigent but does not define what services. On that reading, the board is certainly in a position to give all necessary priority to obstetrics and other true health services. *The Indianapolis News*, October 4, 1973.

## The Road to Health Care

The United States has the best hospitals, doctors, and medical education system in the world. The amount it spends on health is far

above that spent by any other nation. Its citizens pay more per capita annually than anywhere else in the world.

At the same time, however, there's a shortage of 50,000 physicians in the United States; 20,000 qualified premedical students are turned away from U.S. medical schools every year for lack of space; and 40 per cent of U.S. hospital interns are foreign-born. This final point is particularly ironic since most of the interns come from the developing countries of the world, which desperately need their services.

It quickly is becoming apparent, as the nation debates its health-care delivery system, that a tremendous gap separates most health programs from the people they are intended to serve. The various proposals for a national health insurance system are designed to help span this gap, but political infighting over how large a role the government should assume may reduce any plan to a fraction of its potential. A similar fate overtook the National Health Service Corps after it was created three years ago. Congress authorized \$50 million for the corps to use in placing doctors, dentists, and nurses in urban slums and rural areas lacking health professionals. But only a token amount ever was spent, and medical relief to these areas hasn't materialized.

Delivering health-care systems to



the people always has been a difficult task in this country. The American Medical Association began attacking national health insurance as "socialized medicine" as early as 1945, when it was being proposed by President Truman. The United States remains today the only industrial country lacking such a program.

Last year 7.6 per cent of the gross national product went for personal health care. This \$83.4 billion was double the amount spent in 1965, with half of the increase

traceable to inflation. Despite this investment in more and more costly health services, however, an over-all health strategy never has emerged. A national health insurance plan would be only part of such a broad-scale attack on health needs.

Meeting the various challenges in health care, such as providing more doctors and making more medical-school space available, isn't going to be easy or even, in some cases, immediately possible. What is important, though, is to begin the process of establishing health care a national priority, and lifting it from the in-

decisiveness of the past. An obvious starting point would be the resuscitation of the National Health Service Corps and other existing health programs that have withered for lack of leadership and administration interest.

It's past time to forget the political rhetoric that for so long has delayed a concentrated and intelligent look at this country's genuine health needs, and to base future decisions solely on how best those needs might be met. *The Journal-Gazette, Fort Wayne, October 12, 1973.*



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macleric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** if priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be dis-

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**Precautions:** The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

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## Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage inter-professional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that

economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

*Pharmaceutical Manufacturers Association  
1155 Fifteenth Street, N.W., Washington, D. C. 20005*







## Placidyl® (ETHCHLORVYNOL)

### Brief Summary

**Indications**—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

**Contraindications**—Drug hypersensitivity and porphyria.

**Warnings**—Not recommended during the first and second trimester of pregnancy. Caution patients of possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

**Precautions**—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitriptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

**Adverse Reactions**—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 304431

## Give us his nights.

Prescribe Placidyl. Chances are, we'll give him a good night's sleep.

Insomnia may often accompany surgical convalescence. During those long nights following surgery, sleep can be as elusive as it is vital.

When sleep is synonymous with therapy, remember . . . Placidyl is synonymous with sleep. It has been for over 17 years.

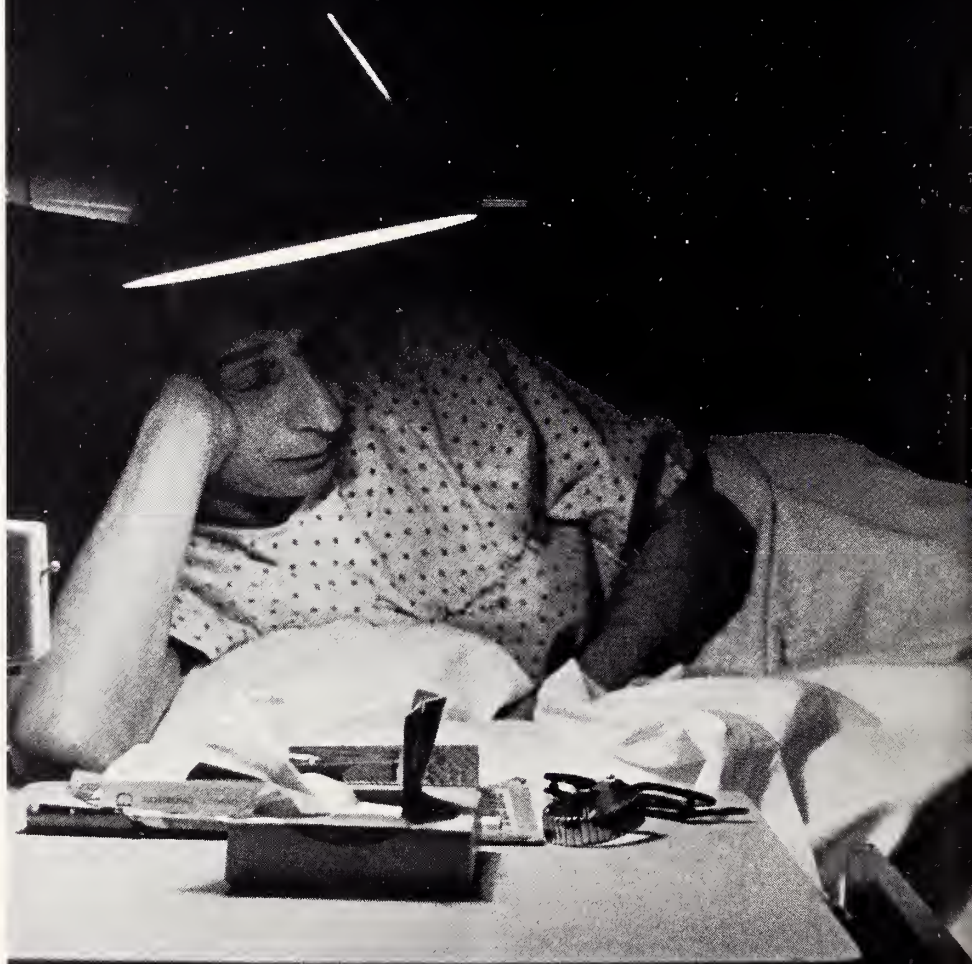
If time is the criterion to inspire your confidence . . . you can rest assured with Placidyl.

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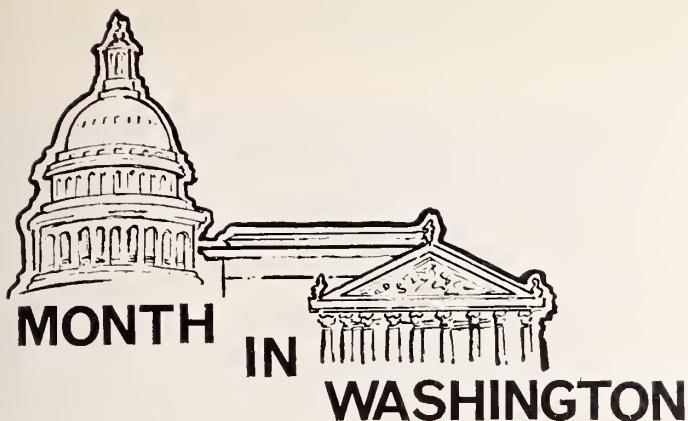
## Placidyl®



(ETHCHLORVYNOL CAPSULES, 500 or 750 mg.)







This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to The Journal on the first of each month preceding month of issue.

**The debate concerning the right of large states to establish statewide Professional Standards Review Organizations (PSROs) has apparently come to an abrupt halt with the government saying "no" in a loud and clear voice.**

The Department of Health, Education, and Welfare announcement came only 10 days after it had released a statement that said under certain circumstances it would consider naming a statewide PSRO in big states where there is support for it among the interested medical and health groups.

Though an about face was denied by Henry Simmons, M.D., Deputy HEW Assistant Secretary for Health and acting head of PSRO, there was an apparent conflict between the statement given earlier to the PSRO Advisory Council and the final decision.

The designated PSRO areas which will be announced by late November or early December will include no area having many more than 3,000 physicians within it, Dr. Simmons told a news conference in his office. He conceded there is no such limitation in the PSRO law, but the 2,500-physician level suggested in the report by the Senate Finance Committee was "reasonable" but not "rigid."

The area selections will be in the form of proposals printed in the *Federal Register* giving interested parties 30 days in which to comment. The possibility remains that some changes could be made before the designations become final, but Dr. Simmons did not talk as if there was much chance of that happening.

In the earlier statement given the Advisory Council, Dr. Simmons said: "There are a few states with a larger number of physicians that have requested that they also be designated as single state PSROs and have obtained backing of their medical, osteopathic and hospital associations and, in some instances, government. In such instances, we will individually consider designation of a statewide PSRO if the statewide PSRO has support of physicians throughout the state and agrees to further subdivide itself . . . and if control of

the review process remains at the local levels. . . .

"Thus, in states with a large number of physicians which nevertheless opt for a statewide PSRO, it is clear that the review of care would be controlled and performed locally. . . ."

Members of the Council interpreted this as indicating that HEW in some cases might okay a statewide PSRO in large states.

Dr. Simmons also told the news conference that guidelines will be issued in February on how organizations can apply to become PSROs within the designated areas. By next June, he said, the hope is to have 50 PSROs chosen. Within four to six weeks a PSRO bulletin will be sent to all physicians in the nation outlining the status of the program and informing them of PSRO developments.

He predicted from 20 to 30 small states will be single-state PSRO areas.

PSRO, said Dr. Simmons, is "probably the most sensitive program that has been mandated" for the medical profession "and one of the most important ever passed in terms of impact upon the profession and benefit to the public."

He praised the AMA for "very constructive steps" in developing diagnostic standards for PSRO and "very constructive work in general" with HEW in gearing up for the program. He conceded a difference of opinion with the AMA on the extent to which PSROs would function at the state level.

**Prior to the HEW decision against statewide PSROs in large states, the Senate Finance Committee had tentatively approved a provision that would ban HEW from using a limitation on the number of physicians that may belong to a PSRO.**

If enacted, the provision could make it easier for statewide PSROs to win HEW approval.

At present, the Department is employing a general

Continued



# THE INDIANA STATE MEDICAL ASSOCIATION

3935 N. Meridian, Indianapolis 46208—Telephone 925-7545

ANNUAL CONVENTION—OCTOBER 7-9, 1974—Indianapolis

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2—Paul W. Holtzman, Bloomington	Oct. 1975
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4—Howard C. Jackson, Madison	Oct. 1974
5—Cleon M. Schauwecker, Greencastle	Oct. 1975
6—Paul M. Inlow, Shelbyville	Oct. 1976
7—John O. Butler, Indianapolis	Oct. 1974
7—Joseph F. Ferrara, Franklin	Oct. 1975
8—Richard Ingram, Montpelier	Oct. 1975
9—William M. Sholty, Lafayette	Oct. 1976
10—Vincent J. Santare, Munster (Chairman)	Oct. 1974
11—James A. Harshman, Kokomo	Oct. 1975
12—John S. Farquhar, Jr. Fort Wayne	Oct. 1976
13—G. Beach Gattman, Elkhart	Oct. 1974

## ALTERNATES

District	Term Expires
1—Bernard Rosenblatt, Evansville	1976
2—Betty Dukes, Dugger	1974
3—Thomas Neathamer, Jeffersonville	1974
4—William Blaisdell, Seymour	1976
5—William G. Bannon, Terre Haute	1976
6—Glen Ward Lee, Richmond	1975
7—John Pantzer, Indianapolis	1975
7—Donald McCallum, Indianapolis	1974
8—Jack L. Alexander, Muncie	1976
9—Max N. Hoffman, Covington	1974
10—Martin O'Neill, Valparaiso	1975
11—Lloyd L. Hill, Peru	1974
12—Walter D. Griest, Fort Wayne	1974
13—Donald S. Chamberlain, South Bend	1976

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Delegates	Alternates
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Terms expire December 31, 1974:

Delegates	Alternates
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## 1973-74 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1.	William Dye, Oakland City	Martin J. Bender, Evansville	
2.	Robert O. Bethea, Farmersburg	J. S. Brown, Carlisle	June 1974, Sullivan
3.	Claude J. Meyer, Jeffersonville	J. L. Millan, Jeffersonville	
4.	Kenneth E. Bobb, Seymour		
5.	J. Franklin Swain, Rockville	Antolin M. Montecillo, Clinton	
6.	James H. Tower, Jr., Shelbyville	Arlington M. Hudson, Connersville	
7.	Eric Clark, Plainfield	M. O. Scamahorn, Pittsboro	
8.	Paul W. Sparks, Winchester	Howard Koch, Winchester	
9.	Milton W. Erdel, Frankfort	Harry T. Stout, Frankfort	June 13, 1974, Frankfort
10.	Mario D. Mansueto, Munster	James R. Brown, Valparaiso	
11.	Joseph S. Bean, Logansport	Fred Poehler, La Fontaine	
12.	Franklin A. Bryan, Fort Wayne	Karl R. Schladeinan, Fort Wayne	
13.	Jack Hannah, Elkhart	David L. Spalding, Mishawaka	Sept. 11, 1974, Elkhart



top limit of 2,500 physicians per review organization, a maximum guide that obviously would foreclose larger states from having a single organization to review institutional care for Medicare and Medicaid patients.

The amendment was sponsored by Sen. Lloyd Bentsen (D.-Texas) and agreed to by Sen. Wallace Bennett (R.-Utah), originator of the PSRO concept and a staunch proponent of smaller PSRO units.

The language of the proposed Bentsen amendment reads: "In carrying out the provisions of this section, the Secretary may designate, as an appropriate area with respect to which a Professional Standards Review Organization may be designated, an area encompassing a whole State; and the Secretary shall not refuse to designate any qualified organization as the Professional Standards Review Organization with respect to such area solely because of the number of physicians participating in such Organization."

Whether or not the Senate committee action on a House-passed measure making technical changes in the Social Security Law would result in a significant change in HEW PSRO policy is not known at this time.

**The present Congress won't act on a full-scale national health insurance program, predicts Sen. Wallace Bennett (R.-Utah).**

Bennett, top Republican on the Senate Finance Committee which has jurisdiction over NHI, said such a national program would require new taxes to finance it.

"Congress is keenly aware of a strong and growing resistance to any increase in taxes for any purpose," he said. "To complicate the situation further, there is a real rivalry between the Administration and the Congress as to which can demonstrate the greatest fiscal responsibility."

"I don't believe the people really realize just how great the added tax burden must be to provide the billions needed to support some of the large-scale programs which have been proposed," Bennett said, adding that a health care bill sponsored by Sen. Edward Kennedy (D.-Mass.) would cost "an estimated \$70 billion."

Although ruling out the possibility of Congressional action on a full-scale national health insurance program, Bennett said it was possible that Congress might act on "some limited type of catastrophic health insurance coverage and improvements in Medicaid."

The Senator was referring apparently to the bill introduced by Finance Committee Chairman Russell Long (D.-La.) and Sen. Abraham Ribicoff (D.-Conn.)

recently for a Social Security-financed catastrophic plan and federalization of Medicaid.

**A growing public and professional awareness of the perils and prevalence of alcoholism and indications society finally is gearing to grapple with the problem meaningfully were reported at the Conference on Medical Complications of Alcohol Abuse presented by the American Medical Association in Washington, D.C.**

Cautious optimism, a feeling that perhaps a corner had been turned, marked the attitudes and statements of many of the 300 speakers and participants at the Conference co-sponsored by the National Council on Alcoholism and the National Institute on Alcohol Abuse and Alcoholism (NIAA).

The meeting came at a time Congress is voting millions of additional dollars for federal alcoholism programs and the Administration is upgrading the effort within the HEW Department.

Morris Chafetz, M.D., Director of the NIAA, said, "it is time we stopped blaming sick people for their own illness and our inability to provide appropriate treatment—especially since the care-givers are in fact the very ones who have conspired to stack the cards against them."

The AMA first recognized alcoholism as an illness back in 1956, Dr. Chafetz said, "yet even today more than half of our nation's hospitals will not admit patients with a primary diagnosis of alcoholism."

The medical profession itself loses 400 physicians, the entire enrollment of a medical school, to alcoholism every year, the psychiatrist said. "When we measure the magnitude of human suffering against the plain reality that alcoholic people are indeed treatable, then I believe that the biggest tragedy and shame of all will occur if the health and medical professions continue to fail to exercise their proper responsibility to help the millions of victims of this epidemic illness."

Another speaker, Maj. Gen. Frank Clay, Deputy Assistant Secretary of Defense (Drug and Alcohol Abuse), cited "noticeable progress" in the military's six-month-old attack on the tradition of the GI as not only a hard fighter but a hard drinker. "Treatment will be available for every individual who wants treatment for alcoholism," Gen. Clay said.

Harry McKnight, Jr., of the Veterans Administration, said the VA operates the nation's largest unified system of alcoholism rehabilitation with 61 special units that handled 131,000 alcohol abusers in the fiscal year 1973.

Continued



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		Frank Deanovic, 1400 Chester Blvd., Richmond 47374
		Russell E. Graf, 1110 Highland Park Circle, Bluffton 46714
		W. Martin Dickerson, 1114 O'Connor Blvd., Monticello 47960
		James R. Roth, 323 N. Chauncey, Columbia City 46725



Marvin Block, M.D., Buffalo, N.Y., said "it is the obligation of the physician and hospital medical staffs as well as other personnel to see that the alcoholic patient receives the treatment indicated in the same way as any other sick person—with care and consideration. When this attitude becomes more prevalent, the stigma of the disease will be removed and people will present themselves for help before the disease is far advanced.

"With the medical profession as the central focus of detection and treatment, the scourge of alcoholism which is so prevalent today can be successfully defeated," he added.

**The total cost of educating a medical student in 1972 ranged from \$16,000 to \$26,000 a year in 12 selected medical schools, the Association of American Medical Colleges reported.** Direct instructional expenses accounted for about 40% of the total educational costs for an undergraduate medical student. Research, clinical activity and administrative and professional activities accounted for the remainder.

**The American Medical Association has proposed a regional center national blood program to resolve the differences among major blood-collecting organizations and meet the threat of a Federally mandated program.**

At a meeting of interested groups, including labor and consumers, at the HEW Department, there was praise for the AMA plan from some participants. But a consensus has not developed immediately. At the AMA's suggestion, a third meeting was called to be held by the AMA in Chicago in a further attempt to respond to the directive of HEW Secretary Casper Weinberger that a national voluntary blood donor system be set up by existing agencies or he will impose a solution through legislation or fiat.

**The American Medical Association has told the Congress that legislation is now appropriate to assure the safety and effectiveness of medical devices.**

However, William R. Barclay, M.D., AMA's assistant executive vice president, told the House health subcommittee that controls should be kept to a minimal level to assure that regulations will not restrict the flow of useful devices to the marketplace.

**The HEW Department has sent the White House a proposed national health insurance program weighted toward catastrophic coverage.**

Though HEW aides insisted the plan was more of a "series of concepts" than a final program, the broad outlines of the HEW scheme are likely to be retained in the final bill sent to Congress next year by President Nixon.

The old mandated employer idea is retained in the new plan. Through private health insurance companies, companies must offer employees minimum benefit insurance protection and pay 75% of the premium tax. Enrollment in a Health Maintenance Organization (HMO) must be allowed workers as an option if available. The label given this plan is Standard Employer Plan (SEP).

For poor people, a Government Assurance Program (GAP) would replace Medicaid. This would offer sliding-scale Federal subsidization for health insurance that would have the same minimum benefits as the SEP plan. The very poor would pay nothing for the premium; those making more would pay up to \$300 a year.

Higher income people not covered by SEP could enroll in GAP.

In no case, under the HEW draft, would any family have to pay out of pocket more than \$1,600 a year in health bills.

The proposal would provide coverage of hospitalization, most physicians' services, some mental health care, limited dental care, and outpatient drugs on a deductible basis. Estimated total cost of the SEP premium is \$600 annually.

The plan calls for a medical credit card for all enrollees. Insurers would pay providers and bill patients for services not covered. ◀





# ISMA Committees and Commissions for 1973-1974

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## FUTURE MEETINGS, SEMINARS, COURSES

### University of Cincinnati Announces First Annual Felson Lecture Series

The first annual Felson Lecture Series will be held March 9 and 10, 1974 at the University of Cincinnati College of Medicine with Dr. Harold G. Jacobson as guest lecturer. Dr. Jacobson is Professor and Chairman of the Department of Radiology at Albert Einstein College of Medicine, Montefiore Hospital and Medical Center.

The UC series was formerly designated as the Freedman Lectures and has been renamed in honor of Dr. Benjamin Felson who recently retired as chairman of UC's Department of Radiology.

Arrangements for attending the lectures may be made by writing to Dr. Jerome F. Wiot, chairman of Radiology, University of Cincinnati Medical Center.

### Eye and Ear Infirmary Sets Course In Laryngology and Bronchoesophagology

The Department of Otolaryngology, Abraham Lincoln School of Medicine of the University of Illinois and the Eye and Ear Infirmary of the University of Illinois Hospital, will conduct a continuing education course in Laryngology and Bronchoesophagology March 18 to 23, 1974. The course is limited to 20 physicians and will be under the direction of Paul H. Holinger, M.D. It will be held largely at the Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, and will include visits to a number of other Chicago hospitals. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested physicians will please write directly to the Department of Otolaryngology, Eye and Ear Infirmary, 1855 West Taylor Street, Chicago 60612.

### ACS Spring Meeting in Houston To Feature Eight PG Courses

The American College of Surgeons announces its spring meeting in Houston on March 25 to 28. Eight postgraduate courses are included in the program. The fee for each course

is \$40, which includes a manual. Registrants are required to register for the main meeting. The meeting registration fee for non-Fellows is \$50. Members of the ACS Credentials Group, dues-paid-up Fellows, and surgical residents may register for the main meeting free of charge.

### Announce Nose Surgery Course

The American Rhinologic Society and the Illinois Masonic Medical Center will conduct a postgraduate course in corrective surgery of the nose March 31 to April 6, 1974. Classes will be limited. For program and registration write Mr. R. Gustafson, 836 Wellington Ave., Chicago 60657. Tuition for the full course is \$350.

### 3-Day PG Course for ER Nurses To Be Conducted at Milwaukee

The Wisconsin Committee on Trauma of the American College of Surgeons will conduct its second annual three-day postgraduate course for nurses involved in emergency care. The dates are April 17, 18 and 19, 1974. The tuition of \$75.00 includes text material, all luncheons and a reception. For more information write Dr. Joseph C. Darin, 8700 W. Wisconsin Ave., Milwaukee 53226.

### Indiana Chapter, ACEP, Announces "Indy 500" Scientific Conference

The Indiana Chapter of the American College of Emergency Physicians announces its "Indy 500" Spring Scientific Conference for May 9-11 at the Airport Holiday Inn, Indianapolis.

For further information, contact H. C. Bock, M.D., 3840 Knollton Road, Indianapolis 46208.

### Chest Disease Congress Scheduled

The XII International Congress on Diseases of the Chest will be held in London, England, from July 7 to 12, 1974. For information write to American College of Chest Physicians, 112 E. Chestnut St., Chicago, 60611. ◀

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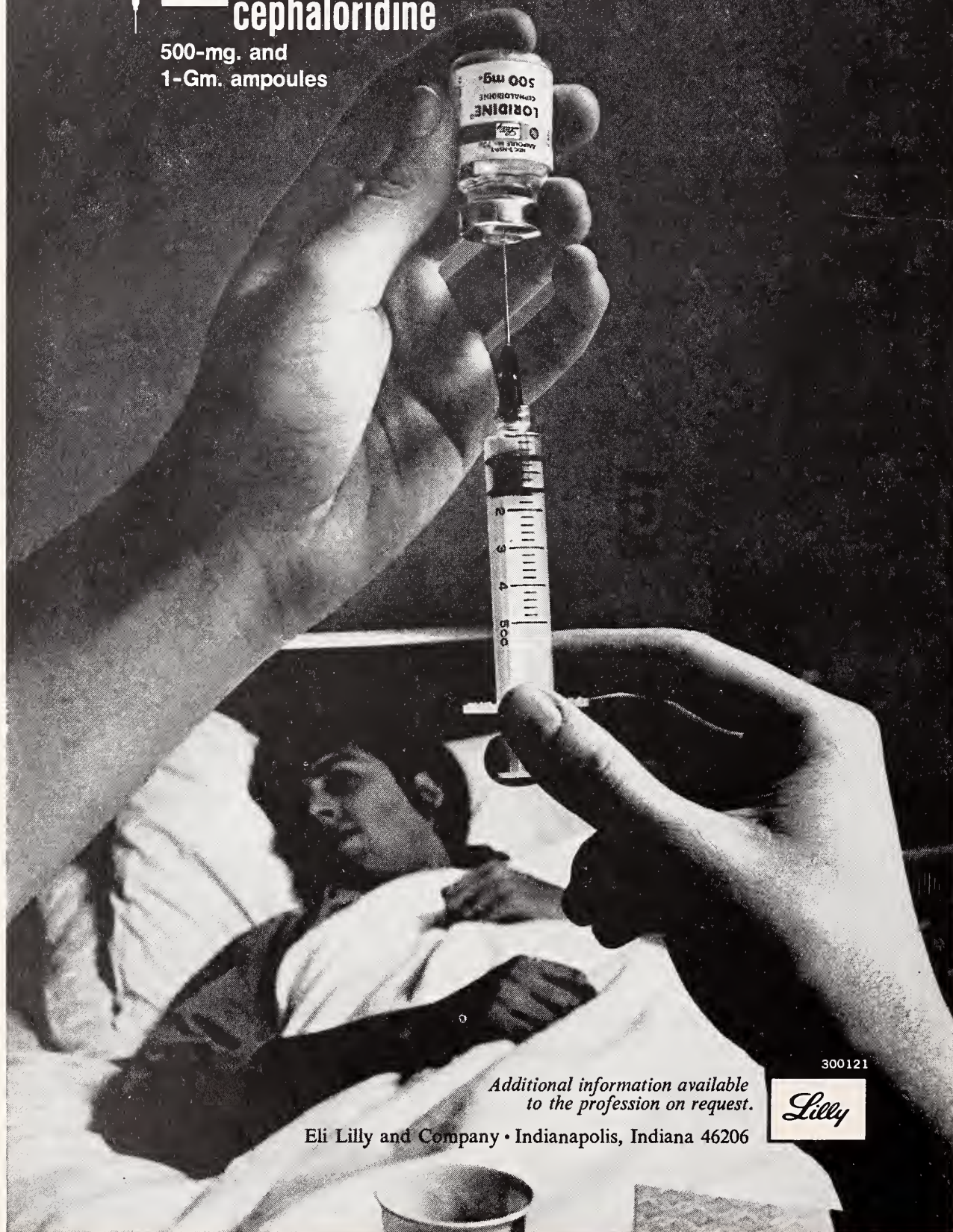
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## Constipation in Geriatric Patients

ROBERT A. BREWER, M.D.  
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THE old saying that familiarity breeds contempt applies to the problem of constipation in geriatric patients. Older patients suffer from and complain about constipation so frequently that the physician tends to take the problem for granted. A cursory review<sup>1</sup> should serve as a reminder of the discomfort that the constipated patient may experience.

Geriatric patients are prone to constipation for various reasons: a decline in peristalsis, poor bowel habits, irregular and inadequate food intake, dehydration and lack of exercise.<sup>2</sup> A complicating factor in the older constipated patient is gaseous distention of the bowel, with resulting pain and flatulence. This may be due to bacterial action in sluggish stools or excessive air swallowing associated with hypersalivation, nervousness, ill fitting dentures, etc.<sup>3</sup>

Constipation and intestinal gas can be associated with serious sequelae. Greenblatt and Barfield<sup>4</sup> reported instances of straining at stool that might have precipitated cardiovascular crises, and Fingl<sup>5</sup> noted that relief of constipation is often of value to prevent straining

by patients with either cardiovascular disease or hernia.

The prescribing of harsh cathartics may result in fluid, protein and electrolyte loss, and the violent purgation which ensues may be severe enough to produce exhaustion.<sup>6</sup> In geriatric patients, constipation is often of the more refractory type and is exacerbated by the low residue diet on which many of them are maintained and by the side effects of a number of the medications which some of them receive.<sup>7</sup>

### Material

A liquid preparation\* that appeared to have the characteristics considered useful in treating constipation in geriatric patients was investigated. The test medication contained 1.25 gm of magnesium hydroxide, N.F., and 100 mg of specially activated simethicone per tablespoon. Magnesium hydroxide is among the blandest and best tolerated remedies for constipation. It stimulates peristalsis indirectly: soluble but unabsorbable magnesium salts are slowly formed in the in-

testinal lumen, thus increasing the fluid content by osmotic force. There is no uncomfortable abdominal distention about which patients using the bulk-producing laxatives sometimes complain.<sup>8</sup> Addition of simethicone to the formulation combats the accompanying gas distress. Simethicone acts by changing the interfacial tension of the small mucus-imbedded gas bubbles, allowing the bubbles to coalesce. In this way, free gas is formed and eliminated more easily.<sup>9</sup>

### Method

After history and physical examination to determine their suitability for admission to the study, the subjects were placed on a dosage of one tablespoon three times daily. No changes were made in activity or gastrointestinal intake. The responses of the patients to the treatment were recorded at intervals of one week over a period of one month.

Of the 85 patients, 33 were males and 52 were females. All had constipation with accompanying intestinal gas symptoms of bloating and flatus. Two patients were in the 50

\*Laxsil, Reed & Carnick.



to 59-year age group, 23 were between 60 and 69, 38 between 70 and 79, 20 between 80 and 89, 1 was 90 and 1 was 91. Twelve members of the study population were nursing home patients and 73 were outpatients. All had been taking other laxatives without significant benefit.

### Results

The test medication worked well in the majority of patients. On the third day after the initial dose, most of those in the clinical trial began to have bowel movements with stools of soft consistency. Before treatment, 45 subjects did not have daily bowel movements. After treatment, the stools of the 3 subjects who did not move their bowels every day were firm rather than hard. Normalization of fecal consistency was observed in 81 of the 85 cases. Insofar as bloating and flatus were concerned, excellent or good results were reported in just under three quarters of the patients.

Detailed evaluations were not made in 18 patients from whom inconsistent or confused histories were obtained. More often, this difficulty was encountered in those who had been placed in a nursing home.

Of the 29 patients with excellent results, 10 reported disappearance of symptoms within one week, 6 within one to two weeks, 9 within two to three weeks and 4 within three to four weeks. Good results, with marked improvement of symptoms, were reported by 20 patients. This occurred during the first week of treatment in 3 cases, within the first 2 weeks in 4 cases, within the second to third week in 10 cases, within 3 to 4 weeks in 2 cases and within more than 4 weeks in 1 case. Eleven of the patients reported fair results, with some persistence of

bloating or flatus. Six reported little relief and only one patient reported no improvement whatsoever.

In common with other physicians who have studied this medication,<sup>2,6,8,9</sup> this worker found that the preparation was well accepted by patients. Its palatability and consistency encouraged good adherence to the dosage schedule.

There were no significant adverse reactions. With geriatric patients, many of whom are already debilitated, the absence of systemic reactions or serious complications was thought to be of particular importance. Four patients reported liquid movements several times a day. Three of the four stopped medication because of this. However, one of this group began taking it again a short time later without difficulty. One patient reported some feelings of nausea that he believed were due to the medication.

### Summary

Constipation often makes the management of geriatric patients more difficult. The effects of a preparation combining magnesium hydroxide and simethicone were studied in a group of 85 elderly and middle-aged patients with constipation accompanied by discomfort from intestinal gas.

The medication proved more effective than magnesium hydroxide alone in softening the stools and improving regularity of bowel movements. Excellent or good results with disappearance or marked improvement of bloating and flatus occurred in approximately three quarters of the patients. The medication was well accepted and caused virtually no adverse reactions, even in the debilitated patients.

### Conclusion

The combination of the laxative,

magnesium hydroxide, with the deflatulent, simethicone, provides a dependable formulation for the effective treatment of geriatric constipation while it alleviates bloating, distention and distress caused by entrapped gas.

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Our Cover . . . brings best wishes for the Holiday Season to all our readers; in addition, it is intended to call attention to our editorial by Congressman William H. Hudnut, III, "The Season of Light" (page 1105). Supported in part by the Mary Rogers Fund.



# *Therapeutic Failure of 5-Fluorocytosine in a Patient with Cryptococcal Meningitis and Pneumonia*

ANTHONY R. DOWELL, M.D.

DAVID E. STIBBINS, M.D.

ARTHUR C. JAY, M.D.

JOAN LIST, M.T. (A.S.C.P.)

Muncie

**5-FLUOROCYTOSINE** is an anti-fungal agent found effective in the treatment of animal and human infections with *Cryptococcus neoformans* and other yeasts.<sup>1,2</sup> A serious drawback to its use in human disseminated yeast infection is the rapid development of yeast resistance to the drug when used in doses of 100 mg/kg body weight/day, or less. The development of in vitro resistance correlates with clinical relapses in several patients reported.

This report is that of a patient with cryptococcal meningitis and pneumonia who initially responded to 100 mg/kg body weight/day of 5-fluorocytosine but relapsed while on therapy. The cryptococcal organism became resistant to the drug within three weeks.

## **Case Report**

A 62-year-old white male was admitted to Ball Memorial Hospital on June 26, 1972, with the chief complaint of frontal headaches described as dull and aching, and not influenced by motion. They had been present for six weeks prior to admission, and were associated with fever and night sweats. He described a "chest cold" in February 1972, which lasted for several weeks and was accompanied by sharp pleuritic

pains in the right chest with inspiration. A five-pound weight loss occurred during this period. Several days prior to admission the patient had a chest X-ray by a mobile unit and a "mass in the right chest" was found. He was referred to his family physician for hospitalization.

He had a known "positive" tuberculin reaction for several years, but had not been treated for tuberculosis. Past medical history revealed he had worked in a "clay pot" manufacturing firm for about 20 years and constructed wet clay molds. He admitted to the presence of "clay dust" in the ambient air from dry clay on the floor and equipment in the building. He had smoked less than one pack of cigarettes per day for 30 years but stopped 10 years prior to admission. The patient had had no prior hospitalizations, injuries, or operations. Family history was noncontributory.

Physical examination revealed an oral temperature of 99.8 F. His heart rate was 92 and regular. The blood pressure was 120/70 mm Hg, and his admission weight was 128 pounds. The physical examination, including examination of the chest and lungs, was described as normal. A chest X-ray on June 21, 1972, revealed a 3 cm circumscribed lesion in the right lower lobe which was present on his film of 1968. Bilateral upper lobe lesions revealed no calcification. An intermediate tuberculin test showed 15 mm induration at 48 hours. Multiple

sputums and gastric washings revealed no acid-fast bacilli or tumor cells, but the patient was begun on isoniazid 300 mg/day and ethambutal 800 mg/day. In addition he was started on 30 mg prednisone daily because his serum cortisol levels were less than 5 µg/ml.

Bronchoscopy was performed on June 28, 1972, and revealed "non-aeration of the right medial basal segment." Smears of bronchial washings showed no acid fast bacilli or tumor cells. On July 1, 1972, a right thoracotomy was performed and a wedge was taken out of the mass for histological examination. In addition, a biopsy was made of the right upper lobe. The histological report was "fibrosis with foreign body giant cells." PAS and Gomori's methenamine silver stains revealed the presence of cryptococci in large numbers. Subsequently, a lumbar puncture was performed which showed an opening pressure of 220 mm H<sub>2</sub>O, a protein of 64 mg%, sugar of 32 mg% and 89 leucocytes/mm<sup>3</sup> with 88% lymphocytes. Cryptococci were found on an India ink preparation. One blood culture revealed the presence of *Cryptococcus neoformans*.

Blood chemistries were normal except for a blood urea nitrogen of 26 mg%. The white blood count was 13,000/mm<sup>3</sup> with 68 polys, 15 lymphs, 11 bands, 4 monos, 1 metamyelocyte, and 1 basophil. The hemoglobin was 15.3 gm% and the hematocrit was 46.3%. Additional

From the Departments of Medicine and Pathology, Ball Memorial Hospital, Muncie, and Muncie Center for Medical Education, Ball State University.



smears for acid fast bacilli were negative.

Treatment was started with 5-fluorocytosine 1 gram orally every 4 hours (100 mg/kg/day). Within 24 hours the headache disappeared. His prednisone was decreased to 10 mg daily and he remained afebrile except for a transient elevation to 103 F. on the third day after treatment was started. Four days after 5-fluorocytosine was begun the hemoglobin dropped to 11.9 mg%. A reticulocyte count at that time was 2.0% and serum haptoglobin was normal. The bone marrow examination was hypocellular. The serum iron was 82 mg%. Cultures of the bone marrow were negative. Direct and indirect Coombs tests were negative.

Three units of whole blood were given and the hemoglobin rose to 15.8 gm%. Weekly spinal fluid examinations showed persistent cryptococci in spite of clinical improvement. No significant change in spinal fluid protein and cell count occurred although the sugar rose to 52 mg% after two weeks therapy. After three weeks of therapy the frontal headache returned accompanied by dizziness, nausea, diplopia and ataxia. He remained afebrile and a lumbar puncture showed an opening pressure of 210 mm H<sub>2</sub>O, a protein of 51 mg%, a sugar of 53 mg%, and 178 leukocytes/mm<sup>3</sup> with 98% lymphocytes. A brain scan was normal and an electroencephalogram showed delta slow wave activity over both fronto-temporal regions. Numerous cryptococci persisted on India ink examination.

The 5-fluorocytosine was discontinued and amphotericin B was given intravenously and, by October 25, 1972, a total of 3000 mg had been given by this route. In addition, 20 intrathecal infusions of amphotericin B were given in doses of 0.5 to 1.0 mg during this same period. The central nervous system

symptoms and signs disappeared following one week of amphotericin B therapy. The patient remained afebrile although his cerebrospinal fluid continued to reveal the presence of cryptococci. In addition, his electroencephalogram became normal, but blood cultures showed cryptococci four weeks after amphotericin B was started. In spite of clinical improvement the cerebrospinal fluid protein remained elevated at 106 mg% and the cell count remained elevated at 33 leukocytes/mm.<sup>3</sup>

### Discussion

The patient had disseminated cryptococcal infection which initially responded to treatment with oral 5-fluorocytosine in a dose of 100 mg/kg/day. Cultures of cryptococci isolated prior to treatment were sensitive in vitro to the drug.<sup>3</sup> Data revealed a minimal inhibitory concentration (M.I.C.) of 1 µg/ml and a minimal fungicidal concentration of 15.8 µg/ml. Following three weeks of therapy with 5-fluorocytosine, the patient relapsed clinically. Organisms cultured from the cerebrospinal fluid at the time of relapse were highly resistant in vitro to 5-fluorocytosine. Sensitivity studies showed an M.I.C. of over 1000 µg/ml. The institution of intravenous and intrathecal amphotericin resulted in further clinical improvement, although cryptococci with altered morphology and capsular loss persisted in the cerebrospinal fluid.

Similar results in patients with disseminated cryptococcal infections have been reported. Frequently the yeast are initially found to be sensitive to 5-fluorocytosine, but become resistant during therapy. In vitro studies by Steer, et al., showed that strains of cryptococci were either highly sensitive or highly resistant to 5-fluorocytosine.<sup>4</sup> They treated two patients with cryptococcal meningitis; one patient initially

responded with clinical improvement, but relapsed and died after therapy was discontinued. The other died 18 months after an 81-day period of treatment which resulted in clinical improvement. Microscopic structures resembling cryptococci were found in the basal ganglia. These two patients were treated with 55 to 71 mg/kg/day for 42 days and 51 mg/kg/day for 81 days respectively. Fass, et al., treated four patients with cryptococcal disease, each with meningitis and one with a pulmonary lesion similar to that of our patient.<sup>5</sup> Two of the patients with chronic meningitis had become unresponsive to amphotericin B therapy. In one of these two patients, the institution of 4 gm/day of 5-fluorocytosine resulted in a dramatic clinical improvement, but the improvement in cerebrospinal fluid was only temporary. Of interest was the fact that the organisms isolated after several months treatment were not inhibited in vitro by 1000 µg/ml of 5-fluorocytosine. It was thought that this patient's cryptococci had developed resistance to the drug during treatment. The other patient with chronic meningitis unresponsive to amphotericin B also showed dramatic clinical improvement following institution of oral 5-fluorocytosine, but the cerebrospinal fluid showed evidence of progressive deterioration and relapse occurred. The cryptococci originally isolated from his cerebrospinal fluid was inhibited by 7.8 µg/ml of 5-fluorocytosine while those isolated about one year after institution of therapy were not inhibited by 100 µg/ml. One patient with combined cryptococcal meningitis and pneumonia received 4 gm/day 5-fluorocytosine and objective evidence of improvement was limited to the changes in cerebrospinal fluid cell count, sugar and protein. The final patient was believed to be eventually cured of cryptococcal infection by 4 gm/day



of 5-fluorocytosine for 17 days followed by 2 gm/day for 2.5 months.

Utz, et al., treated 15 patients with cryptococcal disease with 5-fluorocytosine in doses of 1 to 6 gm/day for 14 to 42 days.<sup>6</sup> Three patients with pulmonary disease responded and cultures became negative. Of 11 patients with meningitis, 9 improved and became culture negative. Of these, four relapsed and three were apparently cured after a maximum follow-up of 18 months. Shadomy reported on 21 patients with cryptococcal disease; 14 with meningitis alone, four with involvement of meningitis and other tissues and three with pulmonary disease.<sup>7</sup> Seventeen patients showed improvement following treatment and four failed to respond. Of the 17 who improved, relapses occurred in five. Of these five, two died of their disease, two were successfully treated with amphotericin and one died of other causes. Vanderveld, et al., reported eight patients with cryptococcal infections treated with 50-150 mg/kg body weight of 5-fluorocytosine.<sup>8</sup> Three of the patients with central nervous system disease were "cured," as defined as disappearance of clinical signs of infection and eradication of cryptococci by cultural and other studies. One of these relapsed, but was re-treated successfully with the drug. Two patients showed no improvement and died of their disease while two improved temporarily but died of other causes. One patient improved with a 90-day treatment with 5-fluorocytosine but continued to have a positive India ink preparation for cryptococci in his cerebrospinal fluid.

The first published clinical trial with 5-fluorocytosine in patients was that of Tassel and Madoff in 1968.<sup>2</sup> They treated two patients, one with candida sepsis and the other with cryptococcal meningitis. The latter patient showed clinical improvement

within two weeks, but the cerebrospinal fluid continued to show cryptococci. After 28 days of treatment, degenerate forms of cryptococci were found in the centrifuged sediment and these were not present after the 35th day of treatment. Therapy with 5-fluorocytosine was continued for 50 days. About one year later the patient developed increased drowsiness, anemia, fever and an occlusion of the right anterior tibial artery and died. Unfortunately, an autopsy was not performed.

The development of resistance to 5-fluorocytosine seems related to inadequate dosage of the drug. 5-fluorocytosine is a fluoropyrimidine compound which inhibits nucleic acid synthesis in a variety of yeasts, including candida albicans, Cryptococcus neoformans, and Aspergillus fumigatus.<sup>1,3</sup> It is likely that the drug leads to a faulty messenger RNA and possibly of defective RNA as well.<sup>9</sup> The effectiveness of 5-fluorocytosine seems dependent upon the concentration introduced into the yeast cell. Shadomy found the drug to be well absorbed from the gastrointestinal tract.<sup>7</sup> He reported mean serum levels of  $16.78 \pm 7.81 \mu\text{g/ml}$  and  $43.89 \pm 18.96 \mu\text{g/ml}$  with oral doses of 100 and 350 mg/kg body weight, respectively, in patients with normal renal function. The drug is concentrated in the urine 9 to 16-fold, even with a creatinine clearance as low as 30 ml/min.<sup>4</sup> In addition, 64% to 88% of the serum level can be achieved in cerebrospinal fluid. Steer, et al., recommend doses of 150 to 250 mg/kg body weight/day for several months in patients with cryptococcal meningitis.<sup>4</sup> The poorest results with 5-fluorocytosine therapy are reported in patients with meningitis, while the best results are obtained in patients with pure pulmonary infection.

Recent work suggests in vitro

synergism between amphotericin B and 5-fluorocytosine against cryptococci. Medoff, et al., suggest that the cell membrane effect of amphotericin B increases the uptake of 5-fluorocytosine in the resistant yeast cell.<sup>9,10</sup> Clinical controlled trials of such a combination regimen have not been published.

The side effects of 5-fluorocytosine include leukopenia, nausea and vomiting, increased serum levels of SGOT and SGPT and hepatotoxicity, the latter occurring in roughly 10% of patients treated and is reversible and probably dose-related.<sup>2,4,5,6,7,8</sup> Tassel, et al., reported one episode of pancytopenia occurring after three weeks of therapy at a dose of 4 gm/day.<sup>2</sup> Our patient developed anemia within one week after instituting 5-fluorocytosine and bone marrow examination revealed moderate hypocellularity of the red cell series.

### Synopsis

A patient is reported with cryptococcal meningitis and pneumonia who initially showed favorable clinical response to oral 5-fluorocytosine in a dose of 100 mg/kg body weight/day. However, after three weeks of therapy, a clinical relapse occurred and was associated with the development of in vitro resistance of his cultured organisms to 5-fluorocytosine. Similar reports were collected from the literature and reviewed.

### Acknowledgement

The authors wish to thank Warren Stibbins, M.D., for the opportunity to help in the management of this patient.

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## INDIANA STATE BOARD OF HEALTH

### MONTHLY REPORT — October 1973

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Disease	Oct. 1973	Sept. 1973	Aug. 1973	Oct. 1972	Oct. 1971
Animal Bites	812	1122	1165	712	920
Chickenpox	68	46	22	100	174
Conjunctivitis	199	317	190	162	124
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	45	188	72	23	14
Gonorrhea	996	1245	1250	671	767
Impetigo	324	434	227	199	218
Infectious Hepatitis	68	61	65	37	43
Infectious Mononucleosis	93	89	45	100	109
Influenza	2511	2298	1211	2584	1391
Measles					
Rubeola	17	24	7	32	15
Rubella	11	18	12	22	40
Meningococcal Meningitis	1	1	0	1	4
Meningitis, Other	2	4	2	3	1
Mumps	167	48	34	27	92
Pertussis (Whooping Cough)	2	8	3	0	0
Pneumonia	443	419	257	361	262
Poliomyelitis	0	1	0	0	0
Streptococcal Infections	1016	1176	655	1056	662
Syphilis					
Primary & Secondary	37	36	22	26	27
All Other Syphilis	88	125	116	73	83
Tinea Capitis	21	17	7	12	0
Tuberculosis (Active)	23	60	45	66	61

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# Comparison of the Screening Tests for Sick Cell Disease

WEI-PING LOH, M.D.

Gary

**R**OUTINE testing for sickle cell disease in black population has gained popularity in recent years. Physicians are frequently asked which of the screening tests is most suitable. I shall attempt to answer this question.

The screening tests for sickle cell disease may be automated at large screening centers or are more frequently non-automated at smaller medical facilities. The automated methods, such as dithionite and dithionite-urea tests, require expensive equipment and experienced personnel. They are extremely rapid and can test 60 to 120 blood samples per hour. Since the non-automated methods are more frequently used, I shall devote more time to analyze them individually.

## Sodium Metabisulfite Test

The principle involved in this oldest non-automated method is that the red blood cells containing hemoglobin S (Hb-S) invariably show sickling effect when mixed with 2% solution of the reducing agent. The technique was best described by Daland and Castle in 1948.<sup>1</sup>

This method offers several advantages. It is simple and only one reagent is required. It is easy to perform in any laboratory which has a microscope. The cost per test is low.

Dr. Loh is the chief pathologist at the Gary Methodist Hospital, Gary 46402 and a Clinical Professor at the Chicago Medical School.

Presented at the Symposium on Sickle Cell Anemia of the Indiana University School of Medicine on October 17, 1973.

One of the disadvantages is that the method requires a microscope and can be inconvenient for field use when mass screening is a must. The method is relatively time-consuming, particularly when the result is initially negative and additional observations after six hours and on the following day are required. The reagent must be fresh. The result could be affected by poikilocytosis or another factor which creates a false-negative picture. The overall accuracy is low when compared with other non-automated methods. Above all, the sodium metabisulfite method cannot differentiate between sickle cell trait (AS) and sickle cell anemia (SS).

## Murayama Test<sup>2</sup>

The principle involved in this test is that the Hb-S and the structural variant Hb-C (Harlem) will gel at 37°C and remain gelled at 0°C.

The test is highly specific. However, the test requires special equipment such as a nitrogen tank and needs 60 minutes for completion. It has not been popular.

## Solubility Tests

The best known test is Sickledex\* which has been thoroughly evaluated by Diggs, Loh and others.<sup>3,4,5,6</sup> We have performed the test on more than 50,000 patients at the Gary Methodist Hospital during the past six years.

The principle involved in this test is that the deoxygenated Hb-S

has low solubility in strong phosphate buffer and forms tactoids to give turbidity. Hb-A under the same condition is soluble and gives a clear solution.

This method has a number of advantages. It is highly specific, highly sensitive and highly accurate. The test requires only minimum equipment and the test kit designed for convenience is commercially available. The test is easy to perform and only takes five minutes to complete. It is a suitable office procedure.

One disadvantage is the high cost of the reagent if commercially purchased. The home-made reagent is cheap but inconvenient to prepare. It is difficult to achieve high and uniform quality. Rare false-positive results are basically related to dysproteinemia, polycythemia, multiple transfusions and unknown factors. Rare false-negative results are basically related to severe anemia, deteriorated reagents, improper technique, etc. The test by itself offers no conclusive differentiation between AS and SS.

Modifications and improvement over the original solubility test are in existence. One major modification is to add centrifugation<sup>7</sup> which can separate the hemoglobins in form of different bands or layers and colors for initial identification. The modification requires additional equipment and time to perform.

## Rapid Electrophoresis

In principle the hemoglobins can be rapidly separated and identified

\*Sickledex—Ortho Diagnostics Co., Raritan, N.J.



in an electrophoretic field when proper controls and suitable buffer are used. Cellulose acetate technique is most practical and can be completed in a few minutes.<sup>8</sup> Citrate agar technique is particularly good for separations of hemoglobins S, D and E.

This test offers a number of advantages, some of which have been previously mentioned.<sup>8</sup> The test is rapid (3 to 15 minutes to complete), highly sensitive, highly specific and highly accurate. It is a confirmatory test and can differentiate among AS, SC and SS. The cost is low, when performed on a large scale.

The few disadvantages are generally insignificant. There is an initial cost for equipment and reagents, amounting to \$400 to \$2,000. The test itself is a little more difficult to perform when compared with the other non-automated methods.

Discussion

A summary of comparison of the major non-automated tests for sickle cell disease is presented in Table 1. If only one method is allowed for the rapid screening, the rapid electrophoresis is the most suitable method. At pH 8.6 in the electrophoretic field, hemoglobins S, D, P, G (Coushatta), Zurich, Lepore, and a few others are known to migrate at an identical rate and therefore cannot be separated. Fortunately, those happenings are rare and they can be differentiated by the

Table 1  
SUMMARY

	Sodium Metabisulfite	Solubility Tests	Electro- phoresis
SENSITIVITY .....	97.0%	98.8%	100.0%
SPECIFICITY .....	High	Nearly 100%	100.0%
ACCURACY .....	88.4%	99-100%	100.0%
TIME (result) .....	30'-24 hr	5 min	3-15 min
TECHNIC .....	Easy	Easy	Less easy
COST (material per test) ..	30¢ or less	50¢ (more or less)	10-15¢

Sensitivity: % of Hb-S persons to give + test.  
Specificity: % of non-S persons to give - test.

solubility tests. Hicks, Griep and Nordschow<sup>9</sup> recently pointed out that solubility tests supplement rather than substitute for the electrophoresis method. Without objection to the high cost and basically for convenience, the Sickledex test should be suitable for physician's office and small screening centers. The positive cases detected by the Sickledex or another solubility technique may then be further studied by the electrophoresis or centrifugation in conjunction with the solubility testing.

For any method, adequate controls and well trained personnel are essential for high accuracy of the test results.

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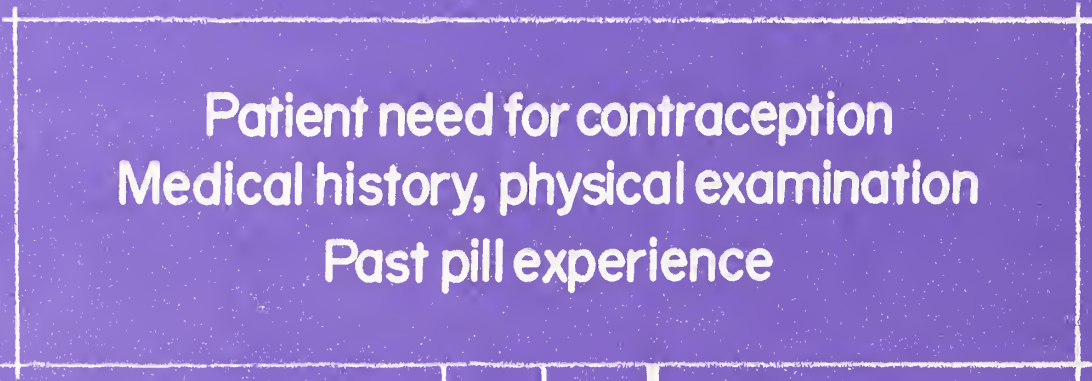
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**Special note**—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

**Indication**—Ovulen and Demulen are indicated for oral contraception.

**Contraindications**—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

**Warnings**—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain<sup>1-3</sup> leading to this conclusion, and one<sup>4</sup> in the United States. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll<sup>3</sup> was about sevenfold, while Sartwell and associates<sup>4</sup> in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as non-users. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

**Precautions**—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of

fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

**Adverse reactions observed in patients receiving oral contraceptives**—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T<sub>3</sub> uptake values; metyrapone test and pregnanediol determination.

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# Advances in Radiotherapy - - Improved Results Following Treatment with High Energy Electrons and 25 MEV X-Ray

## Part Two

JAMES C. KATTERJOHN, M.D.  
Indianapolis

### 24 MEV X-ray Beam

THE value of the Betatron lies in the fact that higher-energy x-rays can be produced. Some of the clinical advantages are as follows:

1. Increased depth dose
2. Greater output
3. Less penumbra or side scatter
4. Greater skin-sparing effect
5. Homogeneous distribution of irradiation in the tissue
6. Large field sizes are possible at long-treatment distances
7. Eight to ten patients, or even more, can be treated per hour
8. Automatic dose control
9. Scattered irradiation is almost entirely in the forward direction
10. Energy absorption per gram in the bone is about the same as in soft tissue
11. Tumor-dose / volume-dose ratio is higher than with lower energy

A comparison of the different energies is apparent from the accompanying diagrams (Figure 6). A mid-line dose in a 20 cm individual is 83% with the Betatron, and 56% with a 2 MEV or cobalt.

Dr. Katterjohn is co-chairman of the Department of Radiology, St. Francis Hospital Center, and associate professor of Radiation Therapy, Indiana University School of Medicine, Indianapolis.

The maximum dose level is 4.5 cm beneath the skin, contrasted with 5 mm maximum dose level in the case of Cobalt 60. Not only is there a remarkable skin-sparing effect with the Betatron, there is sparing of the subcutaneous tissues as well (Figure 7). With the ultravoltage machines, there is less useless irradiation to normal tissues in achieving a desired tumor dose, therefore less radiation sickness.

### Clinical Application

(For the reader's convenience, part of the list of clinical situations where Betatron is indicated and where definite advantage can be realized is reprinted from Part One of this article, which appeared on page 1017 of the November issue.)

(b) Higher energy x-rays for deep seated tumors.

(1) Pelvic irradiation dose to

COMPARISON OF ISODOSE CURVES FOR 200 KV, COBALT AND BETATRON RADIATION

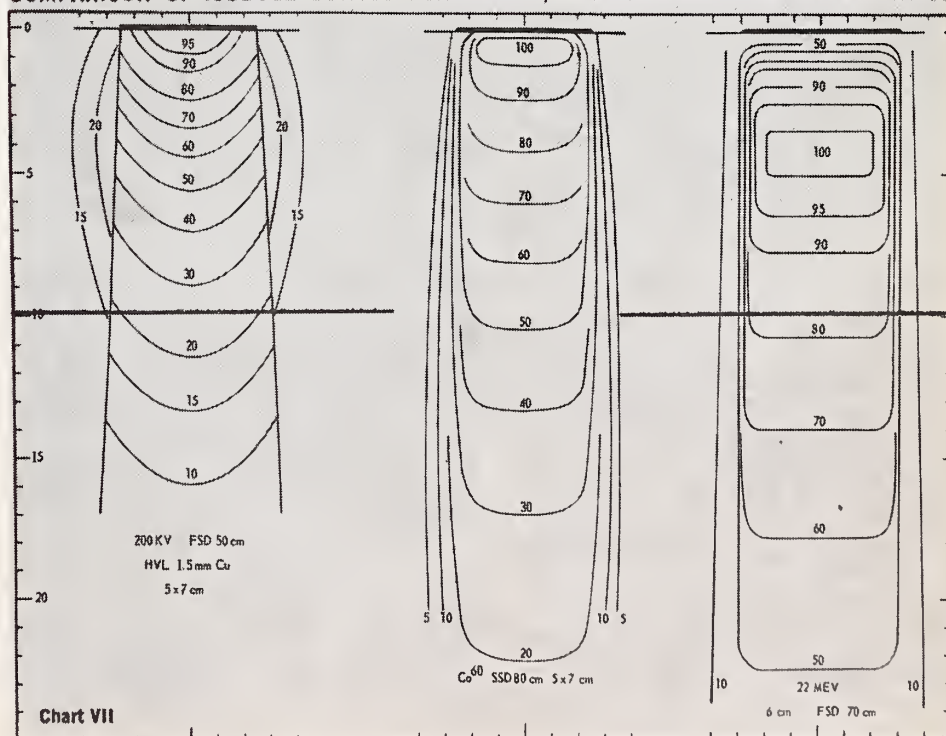


Figure 6

X-ray beam at common energies, orthovoltage, cobalt 60 (=3 MEV) and ultravoltage. Note level of 100% dose at surface, 5mm, and 4.5cm.



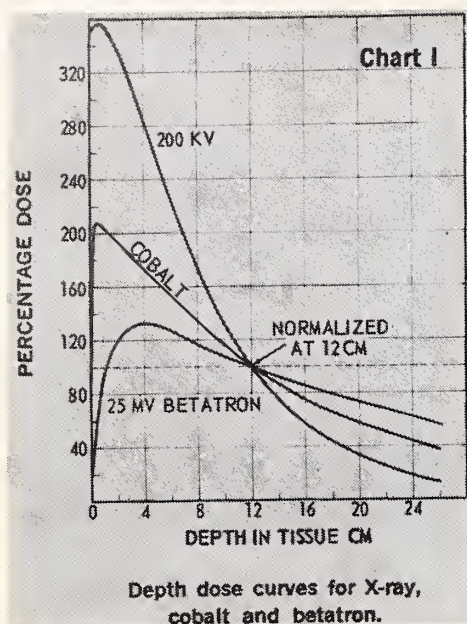


Figure 7

4500 instead of 3000 "r" well tolerated

- (2) Treatment of lung with large anterior portal first for a short period of time to 4000 "r", two week rest and subsequent PA portal localizing treatment to the tumor for a tumor dose of 7000 "r"
- (3) Extended radiotherapy for Hodgkin's disease and other lymphomas, "mantle" technique
- (4) Ovarian carcinoma, moving strip, also used for abdominal carcinomatosis
- (5) Palliative therapy for bowel tumors
- (6) Seminomas and other testicular tumors
- (7) Bladder tumors and prostate
- (8) Extensive metastatic chest lesions are also treated by moving-strip
- (9) Esophagus

The first major gain was realized in the management of carcinoma of the cervix. With the Cobalt 60 device, we used a four-portal technique, two anterior, and two posterior. The usual total dose acceptable to the patient was 3,500 Rad to the tumor. Occasionally we were able to go beyond this, particularly

in thinner individuals, and above the dose of 4,000 Rad if rotational therapy was used. With the 25 MEV Betatron, our usual dose is 4,500 to 4,600 Rad in 23 days elapsed time. Further, we treat a larger portal from the umbilicus to a level below the cervix. Depending upon the radium dosage to the cervix, and the adjacent tissues, we block the midline at 2,000 to 3,000 Rad to protect the bladder and rectum. Even larger doses can and have been given, but there appears to be rather good tumor control in nodes in a dose range of 4,600 Rad plus the radium contribution.

This increased dosage to a larger field is tolerated much better than a lesser dosage utilizing the cobalt apparatus. The tumor-dose/volume-dose ratio is much improved with the more powerful Betatron and radiation sickness is minimized. This is well demonstrated in the accompanying diagram (Fig. 8)<sup>5</sup> and has

been verified by our consultant physicist, Ahren Jacobson of Louisville, who did independent studies for us comparing the cobalt unit and the Betatron.

We believe that our cure rate has been appreciably increased since 25 MEV x-rays have been used instead of irradiation from the Cobalt 60 device. This improved survival and improved patient tolerance is a result of increased dose to all potential lymphatic drainage areas and to more exact radium applications as well. In some instances we also treat the juxta-aortic group of nodes: (1) if there is ureteral obstruction, (2) if we have positive lymphangiogram for disease in the area, (3) if we have surgically proved evidence of disease, and occasionally if there is very bulky tumor in a Stage III disease, where a high presumption of para-aortic tumor is justified. Allt<sup>1</sup> of the Ontario Cancer Institute presented at the 1969 meeting of the American Radium Society

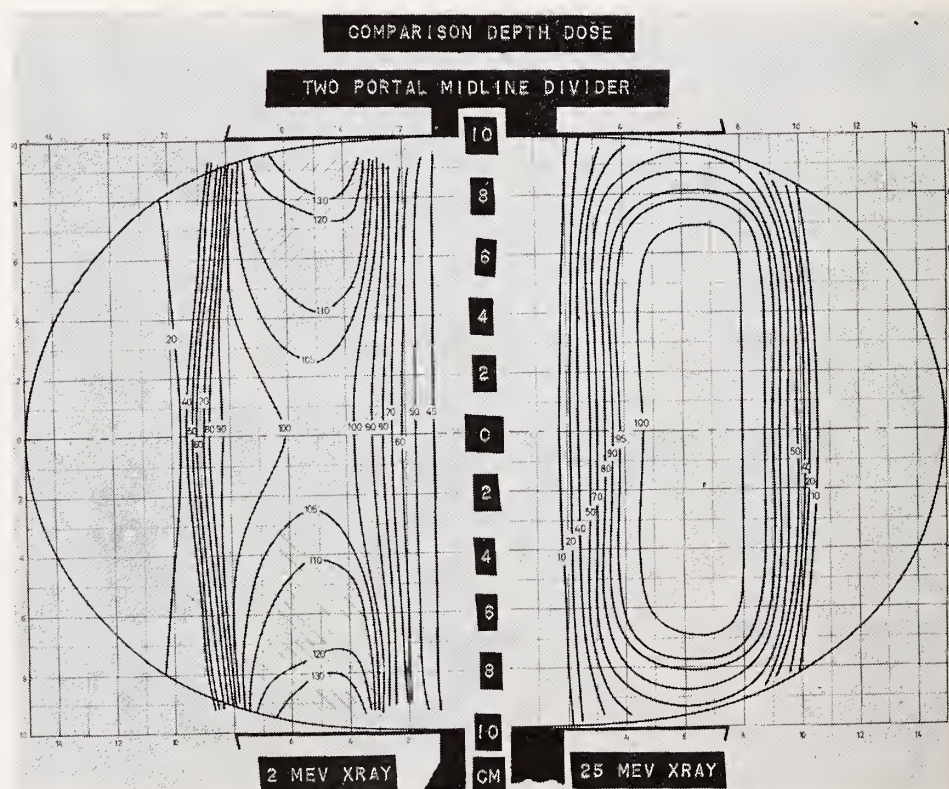


Figure 8

Note useless irradiation in 2 MEV compared to 25 MEV x-ray Surface irradiation 3-4 times greater for 2 MEV in two portal technic. (Chart assembled from data from Atlas of Radiation Dose Distributions, Vol. 2: Multiple-Field Isodose Charts, International Atomic Energy Association, Vienna, 1966).<sup>5</sup>



evidence of the improved survival of Stage II B and Stage III cervix patients treated with the Betatron at 25 MEV over those treated with cobalt in similar dosage ranges. Of 61 patients treated with Cobalt 60 teletherapy, 21 or 34.4% survived five years free of disease. Of 65 patients treated with 25 MEV Betatron, 39 patients or 60% survived five years free of disease. The doses were similar and the survival rate with the Betatron is nearly twice as great in this well controlled series. Dr. Allt believes that this difference is attributable to a satisfactory dose to the larger tumor volume with less radiation to overlying regions outside the tumor than in cobalt treated patients.

It is true, we still have radiation sickness, though reduced in incidence and severity. The usual patient can be treated without interruption. The elderly, debilitated or immediate post-operative patient may require a lower dosage range.

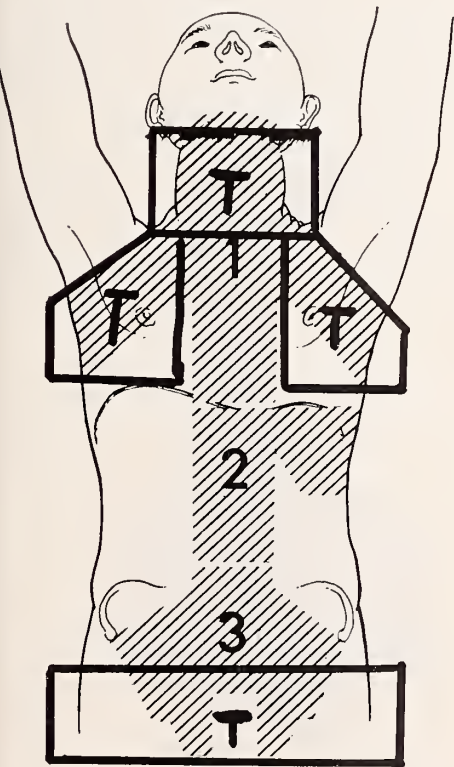


Figure 9

Shaded areas are treated with two or three portals. Areas marked "T" are covered with femex rubber to build up surface dose for more superficial nodes.

Rarely, patients so treated will develop a radiographically demonstrable, but self-limited ileitis. Definitely, our patient tolerance is much better than with treatment in the 3 MEV range (which includes cobalt). Electrons generally have no use in treating carcinoma of the cervix but conceivably we could use electrons to treat the primary lesions transvaginally as we do in the case of intra-oral lesions.

There is little question in our minds that, after treating with the Betatron well over 200 patients with carcinoma of the cervix, our results are better than in patients treated with cobalt in the 1957-1967 period. The survival rate is better and the irradiation side effects are fewer.

Extended field therapy is now established as the best primary treatment for *Hodgkin's disease*,<sup>9,10,23</sup> in all but the advanced stages, e.g., Stages 3-B and 4-B. Therapy consists of treatment through a single portal directed to the entire upper trunk from the diaphragm to the base of the skull. The second portal utilizes treatment from the diaphragm down to and below the inguinal lymph nodes (Figure 9). Because of the superior tumor-dose/volume-dose ratio, the side effects of anorexia and nausea are significantly reduced when compared with those effects following treatment with energies in the 3 MEV range. Extended field therapy was not a popular form of treatment in the early Cobalt 60 era and, of course, treatment with orthovoltage to such extended portals is impossible in this disease. Hodgkin's disease is properly treated by extended irradiation therapy to all lymph node areas, and the best form of treatment for the upper trunk is the "mantle" portal, a single portal to include all lymph node areas from the base of the skull to the diaphragm. The inverted "Y" ( $\lambda$ ) is the preferred

treatment to lymph node areas beneath the diaphragm. Early in our treatment of Hodgkin's disease with the Betatron, we attempted meticulously to place our treatment to the neck, axilla and the mediastinum separately; but I feel certain that sanctuary areas will sometimes remain unless the mantle portal is used. We have adopted the standard "mantle" type portals and the inverted "Y." Because the 25 MEV photons are so penetrating, the 100% dose is situated about 2" beneath the surface of the skin, and the dose to more superficial nodes is not as good as in the case energies of 6 and 10 MEV. To compensate for this, it is a very simple matter to add tissue-equivalent bolus over the neck, axilla and groin areas in order that the nodal dose in the prescribed range can be given. Electron boost is sometimes given to the posterior cervical regions. Special additional portals are added when a splenectomy has not been performed. Our results are comparable to those published by Kaplan<sup>9,10</sup> and we feel that Hodgkin's disease can be treated in a very complete and satisfactory way with the Betatron and certainly more effectively than with the lower energies previously used.

*Carcinomatosis of the abdominal cavity* arising from primary ovarian tumors, bowel tumors and other intra-abdominal and retroperitoneal regions can be treated very satisfactorily with the Betatron with fewer side effects than with lower energies. We have treated many ovarian lesions with the "moving strip" technique without significant side effects, and with better end results than with the lesser energy devices.

One large group of patients presenting for therapy are the individuals suffering from *carcinoma of the lung*. In the 1957-1967 period, carcinoma of the lung was treated with Cobalt 60 through small portals covering the radio-



graphically demonstrated lesion itself with a small margin. The daily tumor doses were usually 200 Rad, which is all we could give without producing radiation sickness. Total doses of 5,500 and 6,000 Rad were administered. The cure rate in our series was less than 5% in a series of 180 patients treated with cobalt. A few remarkable long-term arrests were obtained, and four of these patients still return for follow-up with no evidence of disease. Palliation was reasonably good.

In the case of the 25 MEV Beta-tron, we found that treatment was so well tolerated that we could use much larger portals and a new treatment plan was developed. "One of the main factors in deciding the treatment to apply in a particular case is the knowledge of the potential extension of the disease. In bronchogenic carcinoma, most growth is far beyond the confines of the clinically detectable tumor."<sup>2</sup> Rather than make a futile token gesture with small portals, we have developed a treatment plan which uses a split series. The first portion of the treatment is given through only an anterior portal, including the primary tumor and the mediastinum on the contralateral as well as ipsilateral side (Figure 10). Normal peripheral lung tissue is shielded using lead bricks and, when feasible, the heart is shielded as well. The daily dose of 250 Rads to the tumor is generally well tolerated. The end point for the first portion of the treatment is one of the following three:

1. 4,000 Rad tumor dose,
2. Dysphagia of severe degree, or
3. Cord dose of 3,000 Rad,

whichever of these three comes first. The patient is then furloughed for 10 to 14 days, and if no complications have developed, a second series is administered using the posterior portal directly to the primary

tumor only, avoiding the spinal cord. A tumor dose of 3,000 Rad is given to this portal in the same increments mentioned above, and the average NSD in Rets. is 2,050 or 7,000 Rad in about 55 days. The average mediastinal doses are 1,450 Rets.

Because of the high tumor-dose/volume-dose ratio, very little radiation sickness is experienced despite the use of very large treatment portals. If the scalene node biopsy is positive, or if there are clinically palpable neck nodes, the supraclavicular space or spaces are treated with 25 MEV electrons to 4,000 Rads simultaneously with the treatment at the primary chest lesion.

Patients who tolerate this treatment poorly are those with severe emphysema, cardiac failure and extensive previous tuberculosis. On occasion, it is necessary to suspend the treatment after the first series is given. Obviously, people with hepatic or cerebral metastases do not get the full course. Bloedorn<sup>2</sup> first advocated a more aggressive treatment plan. With our plan, an improved tumor dose is given. This extended-type treatment was instituted when we found patients with arrested primary tumors returning with recurrent disease in immediately adjacent areas, when small portals had been used. The 24

month survival in our series is about 30% in 170 patients and there is much better palliation than in the cobalt-treated patients. Obstructive lesions are reduced in size, and aeration of the diseased lung follows. The final survival rate will be reported later; but it is our impression that a five-year survival in the vicinity of 20% is a reasonable expectation in those patients when the *full course* of treatment has been given.

Radiation fibrosis inevitably develops in this group of patients; but it is usually acceptable, as evidenced in several of our patients, two in particular, who received the full series of treatment and are now engaged in heavy manual labor. One is a 32-year-old policeman who is still able to run up four flights of stairs. Of course, the elimination of cigarette smoking would reduce and eliminate most carcinomas of the lung and render our treatment unnecessary. This is a high-mortality, low-cure type of disease, and we have attempted in our group of patients to administer the best treatment possible despite their poor prognosis. More than a token dose of irradiation has been given.

*Seminomas* and other testicular tumors require irradiation to all lymph node areas up to and includ-



Figure 10

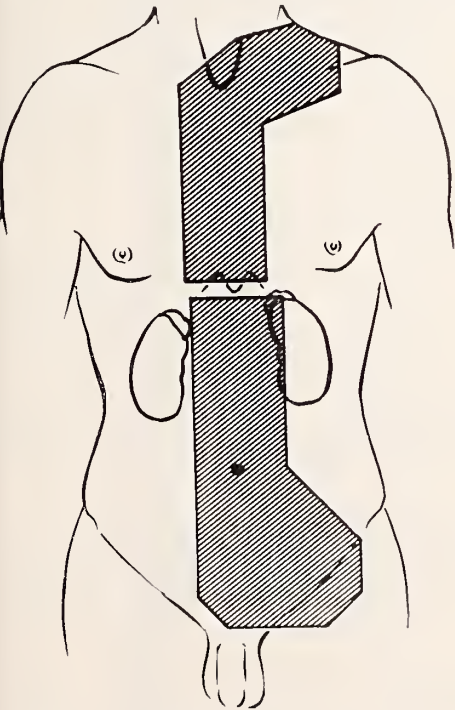
Typical 2-portal set-up for carcinoma upper left lobe of lung. The anterior portal is completed first. Supraclavicular is treated with electrons if disease is present.



ing the neck (Figure 11). It was virtually impossible to accomplish the necessary treatment with orthovoltage therapy and difficult with 1 to 3 MEV therapy. It is much easier to accomplish this therapy with the 25 MEV Betatron.

*The Betatron has some disadvantages:*

(1) Perhaps the greatest disadvantage of the Betatron is the cost of installing and operating a unit. (2) Another disadvantage of the 25 MEV Betatron lies in our inability to generate a sufficient quantity of electrons or x-rays in the lower 4 MEV or 6 MEV range. We are quite limited in the output of electrons below 10 MEV. The ideal addition to our department, then, would be the addition of a unit with energy somewhere between the Cobalt 3 MEV energy and the 10 MEV electron and the 25 MEV x-rays of the Betatron. A linear accelerator of 4 to 12 MEV capability would certainly be a welcome addition. (3) Some very extensive superficial lesions, such as mycosis



**Figure 11**  
Treatment must be given to shaded areas for seminoma and other testicular tumors.

fungoides covering the entire body, cannot be treated very satisfactorily. These lesions are best treated by electron energies in the 2 to 4 MEV range. Our penetration of 3 to 5 cms into the tissue is too great for those individuals with superficial lesions. (4) Excessive heat generation requiring additional air conditioning; and (5) noise produced by the Betatron requiring ear plugs or airline ear muffs.

Finally, it is appropriate to suggest some areas where improvement in cancer therapy, and particularly in radiation therapy of cancer, might be expected to occur. First, it is important that an exchange of ideas regarding treatment techniques be continued and expanded. Also, controlled series and comparison of results when two or more techniques are being used in the treatment of certain cancers should be done.

Since the initial treatment of patients is so important, treatment planning in consultation with other oncologists should be expanded.

In areas where appropriate radiation therapy is not available, efforts should be made to upgrade existing equipment and staff. Since a radiation therapy department and staff is expensive, duplication of facilities should be avoided and existing equipment should be fully utilized. A look at the cost of the St. Francis Radiation Therapy Department might be of interest.

The St. Francis Betatron was purchased for \$130,000 in 1967. The therapy department was relocated within a well-shielded room above the ground and the cost of the entire therapy installation approached \$600,000. The qualified staff necessary, the supportive services necessary and the personnel are expensive. More than 90,000 Betatron treatments have been administered by us since the first patient was treated on July 31, 1967. These treatments have been given to 1,300

Table 1	
TYPES OF CARCINOMAS TREATED	
Breast .....	21 %
Lung .....	20 %
Uterus (Cervix 11 %, Corpus 3%) .....	14 %
Genito-Urinary (Bladder, Prostate, Penis) .....	10 %
Head & Neck (Esp. Salivary Gland & Larynx) .....	8 %
Lymphomas .....	7 %
Brain .....	3 %
Bone .....	3 %
Colon & Rectum .....	3 %
Ovary .....	2 %
Skin (Large Lesions) .....	2 %
Esophagus .....	1 %
Stomach .....	1 %
Pelvic & Abdominal Carcinomatosis .....	1 %
Miscellaneous .....	4 %
<hr/>	
100 %	

patients. Peak daily load with the Betatron has approached 50 patients. The average daily load is 35. After six years, the cost of the Betatron has been amortized, but there are recurring costs such as the qualified technicians, the aides, the electronics personnel and the physicist, as well as the physician administering these treatments. Were the Allis-Chalmers Betatron to be installed in our department today, the initial cost of the machine would be \$200,000. Building costs are advancing rapidly. No doubt the entire installation would cost well over a million dollars. A case load of 35 patients could easily be expanded to twice this number and we could, with the addition of some other equipment, treat 100 patients a day by adding to our staff.

The average single treatment cost would obviously be less if we had a larger volume of patients. There are now two Betatrons in the Indianapolis area. There is a 35 MEV linear accelerator planned at the Indiana University School of Medicine. The 35 MEV energy is not too different from the 25 MEV energy, and the linear accelerator



merely represents a different way of producing high energy x-rays and high energy electrons. In the linear accelerator the field size is larger at 100 cm treatment distance and the output may be greater, but the quality of the radiation is similar. When the Indiana University linear accelerator is completed, there will be three ultravoltage devices in the area serving a population of 750,000 to 1,000,000 people. There is a strong suggestion that two linear accelerators in the 4 to 12 MEV range may be added to other existing hospitals.

In September 1972, at the Seventh San Francisco Cancer Therapy Symposium and at the Seventh National Cancer Congress held in Los Angeles one week later, we were told by authorities from the National Cancer Institute that money was available to fund cancer centers in various parts of the country. The requirements for establishing these cancer centers are quite rigorous, and establishment of such centers requires the complete cooperation of many individuals. The Cancer Center Concept does not mean that there would be a single physical center where all treatments are given. In fact, it is preferred that treatment be given to patients close to their home, if suitable equipment is available. The Cancer Center Concept, therefore, is not a physical cancer center, but a co-operative regional center where all existing equipment is utilized.

One such cancer center has been developed in the Philadelphia area, the Delaware Valley Cancer Center. At the time of its initial proposal in 1970, it would have been impossible for such a center to have been developed. After two years of hard work and many, many conferences, faculty and staff in four Philadelphia Medical Schools and others involved in other major hospitals in the area were able to begin this cancer center with complete co-

operation of all individuals involved. One of the major necessities of such a cancer center is the concept that all patients referred for preliminary evaluation and treatment planning shall be returned to their initial institutions for treatment if proper treatment is available. Certainly such a concept bears investigation, and evaluation, because equipment is quite expensive and should be fully utilized.

Research should continue in all areas concerned with cancer treatment; virology, immunology and genetic engineering are expanding rapidly.

Since increasing voltage for photons has reached its useful peak, other forms of irradiation need to be studied further. Perhaps the neutron therapy device now being considered at the University of Pennsylvania may offer some improvement. The pi-meson device that will be operated by Dr. Kligerman in New Mexico may offer some improvements. Protons with or without ridge filter seem to show great promise.\* These latter developments will probably not be completely studied and reported for five to ten years. It would seem, then, that improvements in cancer therapy will result from cooperation of those individuals currently treating patients and making the maximum use of all facilities available.

The Betatron is not a device that offers utopia for all conditions and for all people. It is merely a better irradiation device than we had used in the past and it permits us to do certain things that could not be done in any other way. Cancer therapy in the future will probably be improved by closer cooperation on the part of the medical, surgical, and radiation oncologists using a co-

\* "Particle Accelerators in Radiation Therapy" Conference Proceedings LA-5180-C, National Technical Information Service, March 1973.

operative approach or some new techniques which are being explored.

### Summary

1. The Betatron has enabled us to deliver a significantly higher dose of x-ray irradiation to deep-seated tumors with fewer side effects and greater patient tolerance and survival.
2. High energy electrons have produced cures in patients where photons were ineffective.
3. High energy electrons can be used to treat a truly localized volume of tissue with maximum sparing of the surrounding regions, e.g., intra-oral treatments and chest wall treatments.
4. With medical costs rising, better utilization of existing equipment and regional long range planning should be paramount considerations.
5. Continued medical investigation and improvement in techniques should be expanded and reported.
6. The peak useful energy of photon therapy has probably been reached. Perhaps treatment with other types of fast moving particles, now under study, may produce additional improvements in radiation therapy.

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# Recommendations<sup>†</sup> on Combination Live Virus Vaccines

## American Academy of Pediatrics

### Committee on Infectious Diseases

In the September 15, 1971 AAP Newsletter sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

<sup>†</sup>For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.



## United States Public Health Service

### Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidity and Mortality Weekly Report*, the Advisory Committee on Immunization Practices of the United States Public Health Service presented recommendations on the use of combination live virus vaccines. The committee stated that:

- "Data indicate that antibody response to each component of these combination vaccines is comparable with antibody response to the individual vaccines given separately."
- "There is no evidence that adverse reactions to the combined products occur more frequently or are more severe than known reactions to the individual vaccines (see pertinent ACIP recommendations)."
- "The obvious convenience of giving already selected antigens in combined form should encourage consideration of using these products when appropriate."



# M-M-R<sup>\*</sup>

## (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

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M-M-R, given in a single injection, fits easily into your routine immunization program for well babies. Given at age 12 months, M-M-R provides for vaccination early in life against measles, mumps, and rubella.

MSD suggested immunization schedule for well babies	
Age	Vaccine(s)
2 months	DPT (diphtheria-pertussis-tetanus) Oral poliomyelitis vaccine (triple)
3 months	DPT <sup>1</sup>
4 months	DPT Oral poliomyelitis vaccine (triple)
6 months	Oral poliomyelitis vaccine (triple)
12 MONTHS	M-M-R (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE, MSD)

1. This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.  
Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

\*Trademark of Merck & Co., Inc.

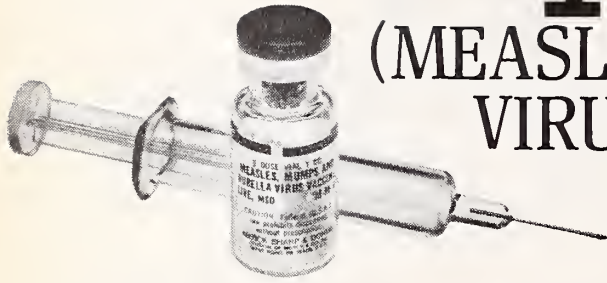
For a brief summary of prescribing information, please see following page.



# M-M-R

## (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials



**Contraindications:** Pregnancy or possibility of pregnancy within three months following vaccination; infants less than one year old; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; therapy with ACTH, corticosteroids, irradiation, alkylating agents, or antimetabolites; blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems; gamma globulin deficiency, i.e., agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia.

**Precautions:** Administer subcutaneously; *do not give intravenously*. Epinephrine should be available for immediate use should an anaphylactoid reaction occur. Should not be given less than one month before or after immunization with other live virus vaccines, with the exception of monovalent or trivalent poliovirus vaccine, live, oral, which may be administered simultaneously; vaccination should be deferred for at least three months following blood transfusions or administration of more than 0.02 ml immune serum globulin (human) per pound of body weight, or human plasma.

Due caution should be employed in children with a history of febrile convulsions, cerebral injury, or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur 5 to 12 days after vaccination.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Attenuated live virus measles, mumps, and rubella vaccines, given separately, may temporarily depress tuberculin skin sensitivity; therefore, if a tuberculin test is to be done, it should be scheduled before vaccination, to avoid the possibility of a false negative response.

Before reconstitution, refrigerate vaccine at 2-8 C (35.6-46.4 F) and *protect from light*. Use only diluent supplied to reconstitute vaccine. If not used immediately, return reconstituted vaccine to refrigerator at 2-8 C (35.6-46.4 F), and discard after eight hours.

**Adverse Reactions:** To date, clinical evaluation has not revealed any adverse reactions peculiar to the combination. The adverse reactions that occurred were limited to those that have been reported previously for the component vaccines.

Fever, rash; mild local reactions such as erythema, induration, tenderness, regional lymphadenopathy; parotitis; thrombocytopenia and purpura; allergic reactions such as urticaria; arthritis, arthralgia, and polyneuritis.

Occasionally, moderate fever (101-102.9 F); less commonly, high fever (above 103 F); rarely, febrile convulsions. Encephalitis and other nervous system reactions that have

occurred very rarely with the individual vaccines may also occur with the combined vaccine. Experience from more than 44 million doses of all live measles vaccines given in the U.S. by mid-1971 indicates that significant central nervous system reactions such as encephalitis, occurring within 30 days after vaccination, have been temporally associated with measles vaccine approximately once for every million doses. In no case has it been shown that reactions were actually caused by vaccine. The Center for Disease Control has pointed out that "a certain number of cases of encephalitis may be expected to occur in a large childhood population in a defined period of time even when no vaccines are administered. A survey conducted in New Jersey in 1965 showed that 2.8 cases of encephalitis (of unknown cause) occurred per million children, ages 1-9 years per 30-day period." However, the Center for Disease Control has analyzed the reported reactions following measles vaccines and pointed out that "the clustering of cases in the period 6 through 13 days after inoculation as well as the recovery of measles virus (probably the vaccine strain) from the CSF of one patient does suggest that some of these cases may have been caused by the vaccine." The risk of such serious neurological disorders following live measles virus vaccine administration remains far less than that for encephalitis with measles (one per thousand reported cases).

Transient arthritis, arthralgia, and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. Such reactions have been reported with live attenuated rubella virus vaccines. Symptoms relating to joints (pain, swelling, stiffness, etc.) and to peripheral nerves (pain, numbness, tingling, etc.) occurring within approximately two months after immunization should be considered as possibly vaccine related. Symptoms have generally been mild and of no more than three days' duration. The incidence in prepubertal children would appear to be less than 1% for reactions that would interfere with normal activity or necessitate medical attention.

**How Supplied:** Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 TCID<sub>50</sub> (tissue culture infectious doses) of measles virus vaccine, live, attenuated, 5,000 TCID<sub>50</sub> of mumps virus vaccine, live, and 1,000 TCID<sub>50</sub> of rubella virus vaccine, live, expressed in terms of the assigned titer of the FDA Reference Measles, Mumps, and Rubella Viruses, and approximately 25 mcg neomycin, with a disposable syringe containing diluent and fitted with a 25-gauge, 5/8" needle. Also in boxes of 10 single-dose vials nested in a pop-out tray with a separate box of 10 diluent-containing syringes.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

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Editor: Frank B. Ramsey, M.D., 3266 N. Meridian Street,  
Room 705, Indianapolis 46208.

Associate Editors: A. W. Cavins, M.D., 75 Allendale Place,  
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Medical Center Bldg., Fort Wayne; I. W. Wilkens,  
M.D., 4820 E. Pleasant Run Pkwy, N. Dr., Indianap-  
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## Guest Editorials

### The Season of Light

William H. Hudnut III\*

THE holiday season which Americans celebrate at the end of December, whether it goes under the specific Christian designation of Christmas or the Jewish appellation of Hanukkah, is primarily a festival of light. The Jewish festival commemorates the purification of the Temple resulting from the victory of the Maccabees in their revolt in Jerusalem against foreign tyrants in 165 B.C. It is also known as the Festival of Lights, centering around eight candles and eight days, being based on a legend in the Babylonian Talmud about a very small quantity of temple oil that burned a miraculously long time until new oil could be consecrated. The Christian holiday celebrates the birth of Jesus Christ as a fulfillment of the Old Testament prophecy that "the people who walk in darkness shall see a great light" and the New Testament belief that Christ is "the light

of the world." And both these festivals coincide, but not merely coincidentally, with the passing of the winter solstice when, in the pagan world of old, it was noticed that the days were getting longer again and the powers of darkness were being pushed back by the unconquerable sun ("Sol Invictus") and the powers of light.

So it might be appropriate for us to ask: If this be indeed a festival of light, what are we doing—what am I doing—to increase the measure of light in the world and diminish its darkness? This season of the year should remind us that each of us is put here on earth to become a source of light in a world needing it desperately as it struggles against the shadows of evil and the curse of darkness. May I suggest three things that we can do to fulfill this divine commission that is symbolized for us by the candles of Hanukkah and Christmas?

First, we can heal—and help—where there is hurt, disease and hardship. The medical profession has a golden opportunity to bring light where the darkness of sickness and physical or emotional illness stalks human life. To channel healing to people (remembering Am-

brose Pare's famous remark, "I dress the wound, God heals it") is a noble task, and any physician or surgeon who has had a good result with a patient, and been the instrumentality for the restoration of wholeness and health to his person, must have experienced the joy and satisfaction and gratitude that characterizes such a moment when the powers of light gain a victory over those powers of darkness, of disease and disintegration and despair, that would drag the soul down to defeat and death.

But in a wider, and non-medical sense, we can all assist in the ministry of healing if we strive to bridge the chasms of misunderstanding that wall people off from each other, and to help people who are distressed. John Wesley once prayed, "Lord, let me not live to be useless," and wise Poor Richard once observed in his Almanac, "The noblest question in the world I can ask, is, What good can I do in it?" If you and I can help bring reconciliation where there is estrangement, peace where there is enmity, justice where there is injustice, and happiness where there is sadness, then we are helping to spread the kingdom of light in the world, and

\*Member of Congress from the Eleventh Indiana District.



being part of the solution rather than part of the problem.

In the second place, we can make fitting observance of the season of light if we seek the truth. Certainly professional medical men who are scientifically trained know the value of research, and can appreciate the importance of pursuing new truth down the labyrinthine corridors of natural law. An open society and a viable democracy require nothing less than an absolute commitment on the part of all citizens, regardless of occupation or station in life, to seek and affirm the truth. Nothing will vitiate the moral fabric of our democracy more quickly, nothing will destroy our freedom more certainly, than an apathetic citizenry which can muster not the slightest moral outrage over falsehood or unprincipled conduct in public or private life. Deceit, corruption, dishonesty, dogmatism, closed-mindedness, fraud, mendacity—these all belong to the worlds of darkness, and he who would liberate mankind from the same and do the works of light should diligently, creatively and bravely pursue and embrace and affirm the truth.

Thirdly, light is spread by positive thinking. Any doctor, like any clergyman, knows the value of positive mental attitudes to the healing process. A person who has no will to live, no desire to get well, no affirmative outlook on life, is defeated in many instances before the application of any therapy. In modern life there are many reasons for giving up, for falling into despair, for becoming discouraged—but the art of living is to go through these things to victorious attitudes beyond—like Robert Louis Stevenson, dying of tuberculosis, who could write: “I believe in an ultimate decency of things; aye, and if I woke in hell, would believe it still.”

Someone has said it is far better in life to light candles than to curse the darkness; and if all of us in our

work, whether it be with patients or clients, constituents or parishioners, can help others develop an affirmative attitude toward life, believing in themselves and their destiny and in the meaning of life—if we can replace cynicism with hope, glumness with cheerfulness, bitterness with love, and emptiness with faith, then we will be contributing to the extension and magnification of God’s light that wants to shine in man’s darkness and not be overcome thereby.

And to what better work could we be called—now at this special holy-day season, or any time throughout the year?

1004 Longworth Bldg.  
Washington, D.C. 20515

### This Experiment is Worth Copying

**J**IFTY Indianapolis high school students were invited to a two-week, all-expenses-paid institute held last summer on the campus of Wabash College. It was called Opportunities L.A.B. (for Learning About Business).

The program was developed by the Indianapolis Chamber of Commerce, Wabash College, and Indiana University-Purdue University at Indianapolis. It was sponsored by 36 companies, many of them among the giants of American business.

As you would expect, the institute included films and lectures on the fundamentals of running a business in modern society. But the organizers had the good sense not to spend all of the time talking “at” the students.

Instead, the key to success was the simulation of an actual business situation. The students were formed into 10 corporations, each engaged (on paper) in the manufacture and marketing of mini-calculators.

The five members of each com-

pany functioned as a board of directors. They had to make decisions about pricing, advertising, financing, and so on, and even engaged in a mock labor negotiation with real businessmen and real union representatives.

Decisions made by the student “directors” were fed into a computer, which reported their theoretical effect on the health of the fictitious companies.

The result of this experience was a dramatic change of opinion among the participants about many aspects of business.

The kids’ comments were typical of teen-agers who have been through similar programs. Here are a few of them:

“I was surprised to learn that businesses tend to make about five percent return on their investment I used to think it was 30 to 40 percent.”

“The course challenged our thinking and I began to appreciate how much thinking businessmen have to do.”

“I learned so much that my outlook on business, the stock market, lobbyists, and government has been changed about 45 degrees.”

“The greatest learning experience of my life.”

Shouldn’t all kids have a chance to participate in something like this? —**Arch N. Booth, Chief Executive Officer, Chamber of Commerce of the United States.**

### Editorial Notes . . .

**The Veterans Administration this year has more than 11,000 employees with physical handicaps serving in 300 occupations.** This represents 6.6 percent of total VA employment. More than 4,200 are amputees or have incurred a deformation. VA reports that 1,216 of the handicapped employees have earned grade promotions in 1973. ◀



# *The New Supplemental Security Income Program*

## *—A Prospectus for the Medical Community*

M. CORNACCHIONE, M.D.  
Indianapolis

ON January 1, 1974, a nationwide program of direct federal payments to aged, blind or disabled persons with limited income and resources goes into effect. Known as "Supplemental Security Income" (SSI), the new program will have uniform eligibility requirements for such persons to replace the multiplicity of requirements existing under the present federal-state public assistance programs.

The Supplemental Security Income program will be wholly financed from federal general tax revenues. Responsibility for administering the program has been given to the Social Security Administration (SSA) not only because of their experience in managing a monthly benefit payment program and the existing SSA advanced data processing system, but also because of the well-established nationwide network of SSA offices and program centers.

The title of the program—Supplemental Security Income—indicates that these benefits are expected in most cases to *supplement* income from other sources, including social security benefits. Those persons receiving public assistance on the basis of age (65), blindness, or disability according to state plans in effect for October 1972 and also receiving such aid for December 1973 will, in general, be converted to the federal rolls beginning January 1974. Further, blind and dis-

abled recipients will continue to be considered blind or disabled for SSI program purposes so long as they continue to meet the definition of blindness or disability under the state plan or the provisions for blindness or disability that apply to new claimants under the federally administered program after December 1973. According to preliminary data, it is estimated that about 6.2 million people including approximately 1.6 million blind and disabled people will be eligible in January 1974 on this basis.

The federal law will pay many people who are not now eligible under state programs because they have income or resources above specified levels, or because their states have requirements making relatives responsible for their care. Also, many people who actually meet the state requirements do not apply for public assistance payments in states which have lien laws. Since the federal law has neither lien law nor relative-responsibility provisions, more people are expected to apply.

The states may, at their own option, elect to supplement the federal SSI payment. Estimates are that about a million of SSI recipients will receive additional state aid beyond the federal payment.

The SSI program will generally use the same definitions of disability and blindness used in the social security disability insurance program for determining eligibility in new claims. To help simplify and speed the process of disability

decisions and to insure uniform treatment of all applicants, no matter where they live, the medical evaluation criteria developed for the Title II disability insurance program (Social Security) with the aid of practicing physicians, medical organizations and the Medical Advisory Committee to the Social Security Administration have been generally adopted for the SSI program. In terms of symptoms, signs and laboratory findings, the evaluation criteria describe impairments that reflect the level of severity that would prevent most people from working for a year or longer. These criteria are constantly being refined to reflect advances in medicine and to take into account disability program experience.

If an applicant has an impairment or a combination of impairments that meets or equals the criteria, and he is not working, he would generally be considered disabled. Most allowances are based on medical considerations alone—that is, the claimant's impairment meets or equals the level of medical severity in the criteria. It is also possible for an impairment to be slight or minimal, thereby resulting in a denial strictly on a medical basis. However, for workers who have impairments which fall short of the listed level of severity but which prevent them from doing their previous or customary work, consideration is given to their ability to do any other work in light of their remaining capacity and of their age, education, training and work ex-

Dr. Cornacchione is chief medical officer of the Disability Determination Division of Indiana Rehabilitation Services, 932 Illinois Building, Indianapolis 46204.



perience. In these cases, the individual must not only have an impairment which prevents him from doing his usual work, or work he has done previously, but also must be unable to do other kinds of work for which he is reasonably suited. In the situation where an older worker with a marginal education and a long history of arduous unskilled physical labor has an impairment which prevents him from doing his usual work, he may be considered under a disability.

All persons whose applications for determinations of disability are adjudicated in a state disability determination unit are referred to the state vocational rehabilitation agency for consideration of rehabilitation service. The states will be fully reimbursed by the federal government through the Rehabilitation Services Administration for the services they provide to qualified disabled and blind SSI recipients.

With the anticipated doubling of the state disability determination unit workloads, emphasis will be placed on expanding resources within the medical community so that we will be able to get medical reports needed for adjudication of claims as quickly as possible. Although generally the same guides apply under Title II and Title XVI there are some differences. For example:

1. *No Waiting Period*—Under Title XVI (SSI), an individual who is determined to be blind or disabled will be eligible for payment for the first month in which he has filed an application and is disabled. There is no set waiting period which must be served after the onset of disability and during which payment cannot be made. (Under Title II, a five-month waiting period must be served after the onset of disability).

2. *Presumptive Disability*—The law provides that an applicant for

disability benefits who is found to be "presumptively disabled" may be paid, under certain conditions, for as many as three months while formal determination of his disability is being made. This provision, along with the absence of a waiting period under SSI, will intensify the need for obtaining medical evidence more rapidly so that disability determinations can be made promptly on claims filed by needy SSI applicants.

3. *Childhood Disability*—With the implementation of the SSI program, the Social Security Administration will for the first time be responsible for disability evaluations and payments for children who are under the age of 18. A child of a family with limited income and resources will be found disabled if the child has a medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for at least 12 consecutive months and is of comparable severity to that which would prevent an adult from engaging in substantial gainful activity. The question of vocational assessment and concomitant ability to engage in substantial gainful activity is generally not relevant in evaluating disability during childhood because, in most situations, the child will not be of age where he could reasonably be expected to enter the working population. Thus, in childhood cases, a finding of disability will be made solely on the basis of medical considerations, including special medical criteria being developed for these cases within the above framework of consideration. There are, for example, severe impairments unique to childhood cases which are not now specifically described in the Social Security Listing of Impairments. The new medical criteria with appropriate signs, symptoms and laboratory findings are being formulated to evaluate these cases.

There will also be a need for frequent pediatric reports under the new program. Similarly, there may be a need for the Indiana state disability determination unit to have pediatricians on its staff or at least available for consultation to review reports on these types of cases.

4. *Drug Addiction and Alcoholism*—The law provides that a disabled person, who has also been medically determined to be a drug addict or alcoholic, shall be eligible for SSI payments only if he is undergoing treatment appropriate for this condition as an addict or alcoholic at an approved institution or facility, if one is available. An eligible individual who has been medically determined to be a drug addict or alcoholic must receive benefits via a representative payee.

5. *Blindness*—The criteria for establishing blindness under SSI are identical to those required to establish statutory blindness under the social security disability insurance program. Unlike Title II, however, engagement in substantial gainful activity will not preclude SSI payments if the statutory definition of blindness is met, although the SSI payments may be reduced under the income test. Also, since there is no duration requirement for blindness under SSI, there can be a favorable decision based on temporary blindness. Once again, the need for comprehensive and prompt medical reports must be underscored.

Implementation of the SSI program will undoubtedly give rise to new questions and point out areas of concern with respect to the medical community and the state agencies. If you have any further questions or desire additional information, please contact Dr. M. Cornacchione, Indiana Rehabilitation Services, Division of Disability Determination, 932 Illinois Building, 17 West Market Street, Indianapolis 46204, or telephone: 633-4533 area code: 317. ◀





## ABSTRACTS, BOOK REVIEWS

### SYNOPSIS OF SURGERY

Edited by R. D. Liechty, M.D., and R. T. Soper, M.D., Iowa City, Iowa, The C. V. Mosby Company, St. Louis, second edition, 1972; \$15.50.

This new edition has 1053 pages and 669 illustrations. It is written by 26 contributors, many of whom are well known writers. The 43 chapters include "Transplantation," "Total Parenteral Feeding" and "Gynecology," which are new additions.

The coverage is complete and up to date. Most of the subjects are well written. This new edition was basically written for the medical students in connection with their new curriculum. It is also highly useful for many physicians and surgeons to update their knowledge.

The paper, printing, binding and illustrations in the book are of high quality. The price is reasonable.

WEI-PING LOH, M.D.  
Gary

### THE FIRST FIVE YEARS, A RELAXED APPROACH TO CHILD CARE

Virginia E. Pomeranz, M.D., Dodi Schultz; Doubleday and Company, Inc., 1973; 248 pages, \$6.95.

The intent of the book is well expressed in the introduction. It is that raising children should be an enjoyable experience for both parents and child, and one which is fitted to the family into which the child is born. Dr. Pomeranz has written an easily read and easily understood realistic and practical approach to the various joys, frustrations and problems involved in raising a child from one to five. The book is well organized and should be of help to both parents and physician caring for family and child. If there is a shortcoming, it is that there is not enough specific detail for questions and problems that may arise. It may be that the author intended the book to be read as an adjunct to another more detailed text.

Information is easy to find in both the "index" and "contents," making the overall value of the book such that it would be worthwhile to have a copy on the library shelf.

ARTHUR C. JAY, M.D.  
Muncie

### CURRENT CONTROVERSIES IN UROLOGIC MANAGEMENT

Edited by R. Scott, et al., W. B. Saunders Co., Philadelphia-London-Toronto, 1972; \$18.00.

The editor and associate editors of this omnibus collection of critical essays are professors of urology at Baylor University, Houston, Texas. The contributors represent a fair cross sec-

tion of American university genitourinary surgeons with a sprinkling of eminent foreigners including Robson of Toronto, Gil-Vernet of Barcelona, and Williams, Turner-Warwick and Swinney of London, England.

As a surgeon becomes more experienced and mature in his art it becomes evident that the therapy of many diseases is a grey area which the human mind can successfully tackle in various fashions. The format of this volume is a clever and balanced method of teaching the nuances of urological treatment. It consists of stating the problem prior to the chapter in a small introduction. Then the essayists present their theses and the chapter ends with a commentary on the preceding dissertations. The editors have chosen 21 topics. A volume such as this could be expanded indefinitely to include many other moot points in urology.

To take an example, consider irradiation treatment for carcinoma. This book considers the problem in chapters on testis tumors, renal carcinoma, bladder carcinoma, ureteral carcinoma and prostatic carcinoma (operable and inoperable). I enjoyed taking sides in my own mind with the essayists. Reading the distilled knowledge of intelligent surgeons considering various facets of a problem in surgery cannot help but be a fruitful teaching method. They also delve into the medical therapeutics of hypercalcuria (thiacide diuretics and salt restriction versus oral orthophosphate salts).

I will not list the controversies of the 21 chapters but be assured that they are problems which we face frequently in clinical practice. Which chapters did I find particularly helpful? All of them.

Almost every surgeon treating genitourinary diseases would benefit from reading the book. It has the sort of knowledge which we need. There is practically no chaff in this book to waste precious time.

RODNEY A. MANNION, M.D.  
LaPorte County

### CRITICAL SURGICAL ILLNESS

James D. Hardy, M.D., W. B. Saunders Co., Philadelphia, 1971; 679 pages; profusely illustrated; \$28.00.

Professor Hardy has gathered no less than 30 distinguished surgeons and had each one write a chapter a score or so pages in length on such specific topics as "Chest Trauma," "Pulmonary Embolism," "Postoperative Fever," "Acute Necrotizing Pancreatitis," "Pulmonary Sepsis," etc.

A real feat of almost legerdemain is performed by the editor in editing, harmonizing and reducing the ever-so-many complex topics to almost medical school level—from the surgeon's standpoint.

This reviewer, being an internist, could record many areas of disagreement—i.e., when is conservative medical management to yield to the surgeon insisting on surgery, stat.? Curiously enough, there are other areas when the surgeon talks medical management as versus my instinct for surgery, right now. These conflicting judgments, in my opinion, underline the very essence of this symposium's value. We are all fallible and many honest discordances are brought to our perusal!

Such a volume as this one has long been needed. Dr. Hardy and his colleagues fill the void well, crisply and ably. I would recommend this book for almost everyone's shelf: right above his desk and within easy reach.

The printing, binding and paper are, as usual for this publisher, beyond reproach. Congratulations all around.

ARNOLD LIEBERMAN, M.D.  
New York



## A SYNOPSIS OF CONTEMPORARY PSYCHIATRY

G. A. Ulett, M.D., St. Louis, Mo., The C. V. Mosby Company, 5th edition, 1972; \$10.90.

This new edition of a concise pocket book has 348 pages which are presented in three parts and 30 chapters. There is a list of suggested readings at the end of each chapter. A few tables are also included.

As an introduction to the complex field of psychiatry, this book is well written and the coverage is surprisingly complete. Part I covers history taking and diagnostic procedures, Part II covers clinical syndromes and Part III covers therapeutic measures. New discoveries and today's techniques are mentioned.

The paper, printing and binding of the book are of high quality. The book should be highly useful to medical student, nurse, mental health worker and physician. The price is reasonable. It is a highly recommended book. My congratulations to the author and the publisher.

WEI-PING LOH, M.D.  
Gary

## MUSCLE PROTEINS, MUSCLE CONTRACTION AND CATION TRANSPORT

Yuji Tonomura, University Park Press, Baltimore, 1973; 433 pages; innumerable figures, electron micrographs, tables, detailed three-dimensional structural formulae, etc.; \$19.50.

The rapidly accelerating increase in our understanding of the exact biochemistry and stereophysics of just exactly what *IS* a muscular twitch and just *how* the actin and troponin fibers (and their sub-units) alter their configuration in contraction and the following relaxation: well! Only a fool would preen himself on his real comprehension of this topic.

And here I was trying to get ready for a joint meeting of half a dozen American experts with their opposite numbers from USSR on precisely this very subject. How did I ever allow myself to get trapped into agreeing to be there, even if my expenses will be paid by NIH?

So, at almost the last minute, I get this gorgeous monograph written by a Japanese top-notch who has the marvelous knack of simple exposition! With a sigh of relief, I sat down and leafed my way through a maze of abstruse—made to look almost simple—speculations, marvelously illustrated experiments, logical, step-by-step chemical changes, complete three-dimensional sketches of the actual alterations; everything made quite understandable.

Remember the proverb anent the Lord caring for drunkards and fools? Well! I don't drink, but the Lord has certainly provided: Praised be his name!

At this conference, I may appear as if I really knew something of the topic. At least, I'll have a gambler's chance at trying!

The whole item is just too marvelous for mere praise. Try it. You may like it, too.

ARNOLD LIEBERMAN, M.D.  
New York



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3004 S. Wayne Ave., Fort Wayne, Ind. 46807

## ISOLATED ORGAN PERFUSION

H. D. Ritchie and J. D. Hardcastle, editors; University Park Press, Baltimore, 1973; 214 pages, numerous tables and black-and-white photographs; \$14.50.

Some dozen top British physiologists have labored long and hard in performing over 1,500 perfusions of various organs under strictly monitored conditions. This tremendous store of knowledge—confirmation of the old and acquisition of the brand new—is then presented for the benefit of the aspiring postgraduate researcher-to-be.

Illustrations are clear and voluminous; the references to the literature almost too profuse. All in all, we have here a most useful, very practical equivalent of a cookbook: the do-it-yourself sort of thing.

One's own prejudices may slant one's comments anent this well-put-together volume. I, for one, would have wanted to see a chapter on perfusion of the isolated heart. Also, the discussion of the interplay of the separate biochemical pathways taken by synthesis and degradation of the individual metabolites might have been a mite less elementary; still, the references to the source materials are not to be caviled!

As usual, the paper, binding and printing are superb. I saw no typos. The \$14.50 price is well within reason. The young aspirant for the Ph.D. would be well advised to get this volume for handy reference. And, even the head of the department might find occasional perusal very much to his advantage.

ARNOLD LIEBERMAN, M.D.  
New York



Abstracts from Various  
Literature, Prepared by AMA

### BASAL CELL CARCINOMA IN CHILDREN

E. B. MILSTONE (Armed Forces Institute of Pathology, Washington, D.C. 20306) and E. B. HELWIG  
*Arch. Dermatol.* 108:523-527 (Oct.) 1973.

The clinical and pathologic features of 22 cases of basal cell carcinoma (BCC) in children, unassociated with xeroderma pigmentosum, nevus sebaceus, or nevoid BCC syndrome are presented, and 25 cases previously cited in the literature are reviewed. In this series, the patients ranged from 7 to 15 years of age, and each had a single lesion. Histologic features resembled those seen in BCC occurring in older age groups, except that fibroblastic proliferation of the surrounding stroma was prominent in many lesions. Most tumors were composed of combinations of solid, adenoid and cystic patterns. There were two fibrosing BCCs and one metatypical BCC.

### TREATMENT OF SEVERE BLEEDING FROM ESOPHAGEAL VARICES

R. SCHRODER (Insspital, Bern, Switzerland) and J. VANG  
*Schweiz. Med. Wochenschr.* 103:1081-1086 (Aug. 4) 1973.

Of 54 patients admitted to a surgical clinic for severe bleeding from esophageal varices, over two thirds had conservative treatment (mainly Sengstaken-Blakemore tube). However, 84% of those who survived and were not operated on immediately experienced further bleeding and required emergency operation. Only 18% of all patients were considered for elective surgery. The results support the present trend towards early emergency operation in patients with severe bleeding from esophageal varices.

### INVASIVE ENTEROPATHIC ESCHERICHIA COLI DYSENTERY

E. F. TULLOCH, Jr., et al. (Walter Reed Army Medical Center, Washington, D.C. 20012)  
*Ann. Intern. Med.* 79:13-17 (July) 1973.

Twenty-eight of 37 persons between the ages of 20 and 55 years suffered acute dysentery from 24 to 48 hours after eating contaminated, imported French camembert cheese. An 0124 *E. coli* was isolated from the cheese and from the stools of nine ill individuals. Biological testing showed this organism to be invasive in character. The predominant symptoms were fever, malaise, tenesmus, abdominal cramping and diarrhea. None of the patients required hospitalization or antibiotic therapy, and most were asymptomatic within one week.

### AORTA-TO-CORONARY RADIAL ARTERY BYPASS GRAFT

A CARPENTIER et al. (Hôpital Broussais, Paris).  
*Ann. Thorac. Surg.* 16:111-121 (Aug.) 1973.

A technique of aorta-to-coronary artery bypass grafting using the patient's radial artery is proposed with the aim of reducing

Continued

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the incidence of late pathological changes in the graft. Experience with 40 radial artery grafts in 30 human patients has shown excellent short-term results and has demonstrated the primary importance of mechanical dilation of the arterial graft before implantation to counteract its spasm.

## EARLY DEVELOPMENT OF INFANTS OF HEROIN-ADDICTED MOTHERS

G. S. WILSON et al. (1801 Allen Parkway, Houston 77019).  
*Am. J. Dis. Child.* 126:457-462 (Oct.) 1973.

Growth and development of 30 infants of heroin addicts were related to the maternal pattern of heroin use and the severity of neonatal withdrawal symptoms. Neonatal withdrawal occurred in 80% followed by signs of subacute withdrawal lasting three to six months in 60% of the infants. Fourteen children were followed one year or longer. At 15 to 34 months of age, children performed within the normal range on formal developmental testing. However, nine children had abnormal findings. Seven demonstrated behavioral disturbances, including hyperactivity, brief attention span, temper outbursts, and sleep disturbance; four of the seven had associated growth impairment. Two children had minor neurological abnormalities. Abnormal findings were more frequent in infants showing severe withdrawal symptoms following continuous heroin use throughout pregnancy. Reported disturbances appear to be unrelated to environmental factors.

## PREOPERATIVE IRRADIATION OF OPERABLE ADENOCARCINOMA OF RECTUM AND RECTOSIGMOID COLON

B. ROSWIT et al. (VA Hosp., Bronx, N.Y. 10468)  
*Radiology* 108:389-395 (Aug.) 1973.

Preoperative irradiation in moderate dose schedule (2,000-3,000 rads/two weeks) followed promptly by surgery has had a favorable effect, when matched with controls, on the survival of male patients with operable and resectable adenocarcinoma of the rectum, particularly when the lesion is low-lying and requires an abdominoperineal resection. There is a

significant reduction in abnormal findings in lymph nodes in the treated group (27%) compared with the controls (40%). With 700 men already in the study, life table survivals at five years are documented at 40.4% for irradiated patients who undergo abdominoperineal resection vs 27.5% for the control group.

## HEART-MUSCLE MAGNESIUM, POTASSIUM, AND ZINC CONCENTRATIONS AFTER SUDDEN DEATH FROM HEART DISEASE

B. CHIPPERFIELD (Dept. of Biochemistry, Univ. of Hull, Hull, England) and J. R. CHIPPERFIELD  
*Lancet* 2:293-295 (Aug. 11) 1973.

Heart muscle from subjects who died suddenly from coronary thrombosis or myocardial degeneration contained significantly smaller concentrations of magnesium than heart muscle from subjects who died from other causes. Mean values for the two groups were 172 $\mu$ g/gm for the heart disease deaths, and 205 $\mu$ g/gm for the controls. There was no significant difference in potassium or zinc concentration between the two groups. These results may be related to the high death rate from cardiovascular disease in soft-water areas.

## TREATMENT OF THYROTOXICOSIS WITH LITHIUM

H. GERDES et al. (Medizinische Universitätsklinik, 1 Emil-Mannkopff-Strasse, Marburg, West Germany)  
*Dtsch. Med. Wochenschr.* 98:1551-1554 (Aug. 24) 1973.

In 20 patients with thyrotoxicosis treatment with lithium acetate orally in doses of 0.5 to 1.5 gm/day resulted in a prompt decrease in the rate of  $^{131}$ I loss from the thyroid gland. A mean fall of 30% in serum  $T_4$  has been observed within seven days. Biochemical changes and changes in  $^{131}$ I kinetics ran parallel with a surprising improvement in the severe clinical picture. Lithium at nontoxic serum levels can promptly lower circulating thyroid hormone concentrations in thyrotoxic patients by blocking hormone release.



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# New Members, Additions to ISMA Roster

**The Journal** welcomes the following physicians who have become members of the county medical society listed and of the Indiana State Medical Association since the publication of the Roster of Members in the June issue.

## ALLEN

Alan R. Gilbert, M.D.  
3030 Lake Ave.  
Fort Wayne 46805

## ELKHART

John B. Collins, M.D.  
236 Simpson St.  
Elkhart 46513

## HENRY

Alejandro V. Gatmaitan, M.D.  
235 East Carey  
Knightstown 46148

## LAKE

Araceli Ternida Acosta, M.D.  
418 Ruta Drive  
Hobart 46342

Srikiatr Dhanavaravibul, M.D.  
6111 Harrison  
Merrillville 46410

Arun Kumar Goel, M.D.  
6111 Harrison  
Merrillville 46410

Vytautas Victor Urba, M.D.  
7905 Calumet  
Munster 46321

## MADISON

Brian D. Stakem, M.D.  
824 Oakdale Dr.  
Anderson 46013

## MARION

Paul Terry Batties, M.D. CD  
4248 Cold Spring Road  
Indianapolis

Henry Feurer, M.D. NS  
Marion County General Hospital  
Indianapolis

Richard Stephens French, M.D. N  
8402 Harcourt Road  
Indianapolis

Michael Joe Jagger, M.D. Resident  
Indiana University Medical School  
Indianapolis

Stanley Henry Kryszek, M.D. OM  
1919 North Capitol Ave.  
Indianapolis

Robert Michael Malachowski, M.D. Resident

Riley Hospital  
Indianapolis

Mohammad Reza Moltaji, M.D. OTO

2725 Crescent Hill Lane  
Indianapolis

Nester C. Reyes, M.D. FP  
Family Health Care Center  
Indianapolis

Robert J. Robinson, M.D. FP  
534 Turtle Creek North Drive  
Indianapolis

Howard S. Sagalowsky, M.D. ANES  
1815 North Capitol Ave.  
Indianapolis

Castoria Seymore, Jr., M.D.  
Ft. Benjamin Harrison  
Indianapolis

Paul S. Strange, M.D. GS  
Methodist Hospital  
Indianapolis

Harold F. Taylor, M.D.  
Nuclear Med.  
St. Vincent's Hospital  
Indianapolis

## MORGAN

Arcadio M. Alarcon Jr., M.D.  
Sunnyside Drive  
Martinsville 46151

## TIPPECANOE

John M. Gossard, M.D.  
2525 South Street  
Lafayette 47904

## VANDEBURGH

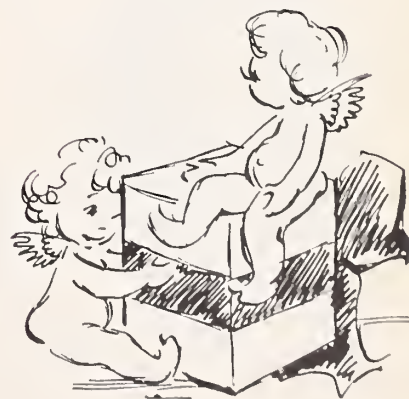
Thomas S. Kandul, Jr., M.D.  
3700 Washington Ave.  
Evansville 47750

George E. Kimmel, M.D.  
600 Mary St.  
Evansville 47747

John D. Pulcin, M.D.  
3700 Bellemeade Ave.  
Evansville 47715

## VIGO

Kenneth Wayne McNeil, M.D.  
903 South 25th Street  
Terre Haute 47803







## TAX TIPS

by LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

### Retirement Plan Deductions

There is still time to establish a qualified retirement plan so as to provide yourself with federal and Indiana income tax deductions for the current year for the contributions which you make under the plan. The earnings on your contributions are exempt from income taxation as the earnings are earned, and there are some income tax advantages when the contributions and earnings are withdrawn from the fund at your retirement, either as a lump-sum distribution or as an annuity. If you intend to organize a professional corporation and utilize one of the qualified plans available to corporations, then you should discuss your situation with your lawyer, accountant, stock broker, insurance representative and banker. The least you should do is to write the Executive Director of any professional association to which you belong and ask him to send you any information which he has concerning qualified retirement plans which are available through the association. However, before you actually establish a plan, be certain to consult your lawyer as

to the current retirement plan legislation which is presently before Congress.

### Year End Sale of Stock

Do you know what is the last day of 1973 on which a cash method taxpayer may sell corporate stock over the New York or American Stock Exchanges in order to have the gain or loss recognized in 1973?

Since a cash method taxpayer does not report gain until he actually or constructively receives the proceeds from a sale, the answer to the question for gain purposes is affected by the period of time that the stockholder has, under stock exchange rules, to deliver the cash to the taxpayer. The New York and American Stock Exchanges require the broker to deliver the proceeds within five business days after the sale date. Thus, a taxpayer may sell his corporate stock on or before December 21, 1973,\* and recognize a gain in 1973. If the taxpayer sells his stock after that date, then his gain will be recognized in 1974, unless he requests that his broker accept a cash sale, in which case the sale could be made as late as December 31, 1973, because the broker would be required to deliver the cash to the taxpayer on the date of the sale.

If the cash method taxpayer has a potential loss on his stock, he is unaffected by the stock exchange rules concerning cash delivery. I.R.C. §165 allows a loss deduction in the year in which the loss is incurred, regardless of when the sale proceeds are received. Thus, if stock is sold at a loss as late as December 31, 1973, the loss must be recognized in 1973, regardless of when the proceeds are delivered

\*Note—this date may be changed to an earlier date where, for example, the New York Stock or American Exchanges decided to close on an earlier date than they now plan to.

to the taxpayer.

However before you sell any stock at a loss during 1973, remember that if you have an excess of long-term capital losses over your capital gains, then you may lose a deduction for 50% of the excess losses. Thus, if you can recognize any capital gains now in order to eliminate any of your present excess long-term capital losses, you probably should do so. Also, you should consider delaying the recognition of any more of your long-term capital losses until 1974, when you will have another opportunity to recognize some capital gains.

### Subchapter S

If your corporation uses the calendar year as its taxable year, consider having it elect treatment under Subchapter S of the 1954 Internal Revenue Code for its taxable year beginning on January 1, 1974. To do so, the election statement (I.R.S. Form 2553) must be filed on or before January 31, 1974. In general, the shareholders also must file their consent statements on or before January 31, 1974. However, because of the recent changes concerning the amount of income on which a shareholder-employee will be taxed, due to a corporation's contribution on his behalf to a qualified retirement plan, it may be wiser not to elect Subchapter S. Further, Subchapter S corporations may want to terminate their Subchapter S elections now because of these changes. In any event, consult your lawyer now in order to have him determine the proper course of action for you and your corporation.

### Tax Saving and Good Investment

If you think that you will be in an income tax bracket of 40% or more for 1973, then this tip is especially for you. Call your stock-

Continued



broker, at once, and ask him to send you one or two prospectuses for investments in limited partnerships which are organized for developing and managing income producing real estate. If you invest, e.g., \$5,000 in such venture, you could obtain, even at this late date, an immediate ordinary income tax deduction of \$2,500. And, in a 40% income tax bracket you would save \$1,000 of income taxes for 1973. Further, you will generally receive tax-free income of 7% to 9% (on your investment) each year in the future. When the venture ends, and the partnership liquidates, you probably will receive capital gain rather than ordinary income. ◀

From The Journal 50 Years Ago

In treating ordinary pharyngeal diphtheria I have seen very little in massive doses of antitoxin, especially if given early and by the intravenous route. Seldom is it necessary to administer more than 100 units per kilogram of body weight as prescribed by Schick and oftentimes less will suffice. Oftentimes I give one-third of the dose by vein, one-third intra-muscularly, and one-third subcutaneously, thus having a reservoir of antitoxin to combat the toxin that is being absorbed from the pharynx.

There seems to be a prevailing idea that cases of laryngeal diphtheria need massive doses of antitoxin. A suffocating individual is given thousands of units, whereas, immediate intubation is more imperative, for the amount of membrane formed and the amount of tissue involved may be small compared to an ordinary pharyngeal case. Intubation may rightfully be spoken of as a lost art, and only with difficulty can one find an intubating set in the average community. Hoyne rightfully criticizes medical schools in their neglect to teach students the art of performing this operation which is far more difficult than doing a tonsillectomy or an average appendectomy. Certainly practice on the cadaver could be performed to much advantage. Hoyne clearly shows the value of trained help in this regard by the marked reduction of the mortality rate in cases of laryngeal diphtheria at the Chicago Municipal Contagious Disease Hospital. Owing to the laxity of tissues intubation of a Mongol is a most difficult operation.

Post-diphtheria paralysis is of most concern when it is of the diaphragmatic type, bilateral cases of which are practically always fatal. Various stimulants and modifications of the pulmotor have been used, but here again prevention is much more important and effective. Contrary to some opinions Mixsell and Giddings from many observations logically conclude that the more severe the anginal attack, and, the greater delay in antitoxin administration, the more likely is the patient to develop a paralysis. . . . L. POTTER HARSHMAN, M.D., Fort Wayne, "Diphtheria Control," JISMA, Dec. 1923.

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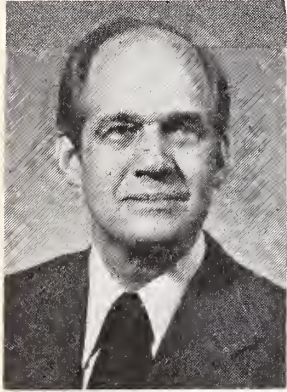


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### Dr. Gilbert Wilhelmus Named President-elect



Dr. Gilbert Wilhelmus, Evansville, was chosen president-elect of the Indiana State Medical Association at the 124th annual convention in October. During the past year Dr. Wilhelmus has served as chairman of the Board of Trustees of ISMA. He has also served as president of the First District Medical Society and is a past president of the Deaconess Hospital Medical Staff. He is also on the St. Mary's Hospital Medical Staff.

A graduate of the St. Louis School of Medicine, Dr. Wilhelmus has been active in the sports and medicine field in Evansville. He is team physician for Harrison High School, consulting physician for the athletic program in Evansville high schools, and a member of the ISMA Sports and Medicine Committee.

He is also a member of the American Medical Association and the American Academy of Family Practice.

### College of Surgeons Inducts 28 Hoosiers

Twenty-eight Indiana surgeons were inducted into Fellowship in the American College of Surgeons recently. They are:

Bloomington: **William R. Pugh**; Bluffton: **Robert D. Nicols**, **Gloria L. Shinn**; Crawfordsville: **Jose Peralta**; Danville: **Thomas J. Hibbeln**; Evansville: **John A. Bizal**, **Stephen C. Ferguson**, **Elizabeth Sowa**; Mell B. Welborn, Jr.

Also, Fort Wayne: **John M. Hoog**, **John R. Thomas**; Gary: **R. James Bills**; Indianapolis: **James A. Crossin**, **Alfredo B. Gonzalez**, **Jay L. Grosfeld**, **Eugene M. Helveston**, **Richard E. Lindseth**, **James A. Madura**, **Thomas S. Moore**, **William S. Sobat**, **James W. Strickland**, **Elvin Glenn Zook**.

Others named are: Kokomo: **Howard M. Van Denbark**; Michigan City: **Florian M. Predd**; Muncie: **John D. Tharp**; Seymour: **Ian S. Templeton**; Shelbyville: **James M. Lorber**, and South Bend: **Ralph V. Ganser**.

### PMA Grant Program Enlarged

The Pharmaceutical Manufacturers Association Foundation has enlarged its program of grants to medical students interested in pharmacology-clinical research. The program, which previously awarded \$1,000 to students who wished to spend three-month periods in research, now allows \$5,000 for one-year full-time research. A candidate for fellowship must be enrolled in a medical school and must have completed at least one year of the curriculum.

### Dr. Krabill Receives MPH Degree

**Dr. Willard S. Krabill of Goshen** received the Master of Public Health degree at the University of California School of Public Health last June. Dr. Krabill is college physician for Goshen College.

### Centenarian Subject of Article

The Bulletin of the Los Angeles County Medical Association reports that **Wilbur Lucas, M.D.**, who was born June 22, 1873, near Fairmount, Indiana, retired from active practice in California in 1958 and since then has been in active retirement. He lives at the Physicians Home, walks at least a mile each day, plays the piano for 90 minutes daily, and this fall will fly to Evanston for the Northwestern-Minnesota football game. Dr. Lucas received the M.D. degree at Northwestern in 1903.

### Dr. James Price Appointed

Wayne Stanton, Administrator of the Indiana Department of Public Welfare, announces the appointment of **James O. Price, M.D. of Indianapolis**, as Medical Director of the Department. Dr. Price, who has served with the department since December 1972, assumed his new duties on October 1. He succeeds **I. W. Wilkens, M.D.**, who is now in retired status.

### Council of Otolaryngology Offers Placement Services

Communities in need of an otolaryngologist are invited to seek the assistance of the American Council of Otolaryngology, 1100 17th St., N.W., Washington, D.C. 20036. The Council maintains a directory of trained otolaryngologists who are looking for a practice site. It also lists in its newsletter the communities that need such specialists.

### Recent Certifications Announced By Board of Orthopaedic Surgery

The American Board of Orthopaedic Surgery has announced the name of Indiana physicians who have attained certification by that Board in 1973, as follows:

Drs. **John W. Follows, Jr.**, Indianapolis, **Marvin E. Gold**, Valparaiso, **Earl J. Heller**, South Bend, **Daniel J. Herman**, Vincennes and **James B. Steichen**, Indianapolis.

### Two Amendments to FDC Act Offered

**Tim Lee Carter, M.D.**, Republican Representative in Congress from Kentucky, has introduced bills to amend the food, drug and cosmetic act to require the FDA, in withdrawing approval of a drug, to take into account clinical experience accumulated subsequent to the drug's initial approval. At present, approval of a product's new drug application can be arbitrarily rescinded if the drug has not been tested in accordance with standards developed after the drug's initial approval. The second amendment would give manufacturers the right to obtain review by an outside advisory committee if a new drug application was refused. The advisory committee would be composed of experts nominated by the National Academy of Sciences.



## Addresses National Symposium

**Governor Otis R. Bowen** addressed a meeting of the National Childhood Cancer Symposium in Indianapolis recently.

## Dr. John Read Presents Paper

**Dr. John E. Read, Chesterton**, read a paper on traumatic hyphema before the recent convention of the American Academy of Ophthalmology and Otolaryngology. **Dr. Morton Goldberg** of Chicago was a co-author of the paper.

## New Cancer Booklet Available

"Can We Conquer Cancer?" is the title of Public Affairs Pamphlet No. 496. Written for laymen, the 28-page booklet discusses the nature of cancer, the research for better controls, the means for curing and palliating now available, and the inexplicable situation of the public which, by and large, does not take advantage of protective measures which are well proven. The price is 35 cents. The address is 381 Park Avenue South, New York City 10016.

## Medal Awarded Dr. William Province

The highest honor of the Mississippi Valley Conference on Tuberculosis and Respiratory Disease was awarded to **Dr. William D. Province, Franklin** internist and commissioner of health for the Johnson County Health Department, recently.

The award, the Dearholt Medal, was presented during the closing session of the organization's biennial meeting in Columbus, Ohio. Some 300 TB-RD workers, physicians and volunteers from 13 states attended the three-day meeting.

## Ciba Medical Illustration Offer In November Not to Be Repeated

The unusually attractive offer of the Ciba Collection of Medical Illustrations by Frank H. Netter, M.D., which appeared in the Ciba advertisement in our November issue, will not be repeated in subsequent issues. There is no limitation on the offer itself, but the advertisement was for one time only. Readers who wish to order the "Collection" should utilize the coupon in the November issue.

## Fire Protection Booklets Offered

The National Fire Protection Association advertises two books, one a 48-pager "Tentative Standard for the Use of Inhalation Anesthetics in Ambulatory Care Facilities," and the other a 96-pager, "Tentative Standard for the Safe Use of Electricity in Patient Care Areas of Health Care Facilities." The first costs \$1, the second \$2. The address is 60 Battery-march St., Boston 02110.

## Physicians Appointed by Governor

**Dr. Oscar Green, Indianapolis**, has been appointed by Governor Otis R. Bowen to a four-year term on the State Board of Examiners on Speech Pathology and Audiology.

**Dr. Kenneth Bobb, Seymour**, has been reappointed to the Madison State Hospital Committee by Governor Bowen.

**Dr. Eugene G. Roach**, acting superintendent of New Castle State Hospital, has been named to a two-year term on the planning and advisory board of the division on mental retardation and other developmental disabilities of the Indiana Department of Mental Health.

**Drs. Edward P. Mininger, Elkhart**, and **Dr. Barbara Backer, LaPorte**, were recently reappointed to the Beatty Memorial Hospital Advisory Committee.

## Schedule of Upcoming NCME Programs

Here are the playing dates and upcoming programs to be distributed by the Network for Continuing Medical Education (NCME):

December 3-  
December 16      **EMERGENCY CLOSED TUBE THORACOSTOMY**, produced by the Center for Continuing Medical Education, Ohio State University College of Medicine, Columbus.

**DIAGNOSING AND TREATING STRABISMUS**, with Virginia Lubkin, M.D., Ophthalmologist and Clinical Assistant Professor of Ophthalmology at Mt. Sinai School of Medicine, New York City.

**DRUG INTERACTION: THE CASE OF THE PUSHY ANTIBIOTIC**, with Harold C. Neu, M.D., Chief, Infectious Diseases, Columbia University College of Physicians and Surgeons, New York.

December 17-  
December 30

**DIAGNOSTIC THORACENTESIS — PRINCIPLES/METHODS**, produced by the Center for Continuing Medical Education, Ohio State University College of Medicine, Columbus.

**LYMPHANGIOGRAPHY IN DIAGNOSIS AND THERAPY**, with Robin Caird Watson, M.D., Chairman, Department of Diagnostic Radiology, Memorial Sloan-Kettering Cancer Center, and Associate Professor of Radiology, Cornell University Medical Center, New York.

**DIAGNOSING COMMON EYE INFLAMMATIONS**, with Virginia Lubkin, M.D., Ophthalmologist and Clinical Assistant Professor of Ophthalmology at Mt. Sinai School of Medicine, New York.

For more information about NCME write the Network for Continuing Medical Education, 15 Columbus Circle, New York 10023.

(Program scheduling subject to change)

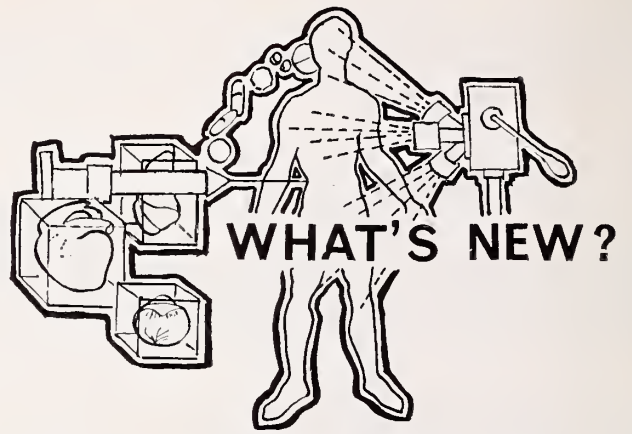


## Norton Hospitals Complex Moving Plans Announced

The Norton-Children's Hospitals complex of Louisville is nearing completion. The Children's Hospital will move into the new building during the week-end of December 15-16. The Norton Memorial Infirmary will follow two weeks later, moving the weekend of December 29-30. The Children's Hospital patients will be transferred between the hours of 8:00 a.m. and 11:00 a.m., Saturday, December 15. The Children's Hospital patient move should not be difficult because the hospital is connected on all levels to the new complex by pedestrian overpasses.

The move of the Norton Memorial Infirmary will be a major undertaking with equipment and supplies being moved on Friday, December 28, and continuing to be moved throughout the weekend prior to New Year's Eve. Norton patients will be transferred between the hours of 7:00 a.m. and 11:00 a.m., Sunday, December 30. The patient evacuation plan is being developed to the finest detail, and fully equipped ambulances will transfer every bed patient comfortably, while at the same time providing the level of care appropriate to the patient's need.

The Norton Memorial Infirmary and the Children's Hospital intend to provide continuous service throughout this period. For additional move information, please contact the Norton-Children's Hospitals, telephone number 583-5566. ◀



Upjohn expects to market a prostaglandin soon. It will be the first to be introduced in the U.S. The preparation, Prostin F<sub>2</sub>alpha, is intended for use in second trimester termination of pregnancy.

\* \* \*

American Gas and Chemicals announces the availability of two Leak-Tec liquid formulations, both of which instantly create a tell-tale stable white form at oxygen leak sites. Very slow leaks may be identified. Recommended for intensive care installations, anesthesia complexes and hyperbaric chambers. Leak-Tec liquids are non-flammable, non-irritating and non-corrosive.

\* \* \*

Norcliff Laboratories announces their A-200 Pyrinat Liquid, the nation's leading pediculicide, as now available in gel form. The new product has the same basic formula as the liquid form and kills head, body and crab lice and their eggs on contact.

\* \* \*

Behavioral Publications announces a new book "Before Addiction: How to Help Youth." Most of the teenage discussion and advice nowadays refers to the addicted adolescent. This book is for worried parents whose children are not yet addicted. It is also recommended for the professional who seeks to communicate with the adolescent and his family. Price—\$7.95 hard-bound.

\* \* \*

Mensor has an Electronic Nerve Activator which is designed to aid certain stroke victims in walking by functional electrical stimulation of the peroneal nerve. It achieves effective ankle dorsiflexion and eversion during gait training sessions.

\* \* \*

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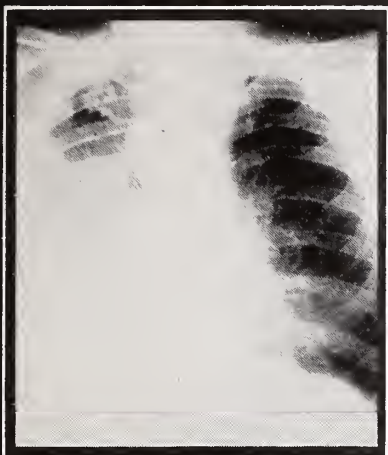
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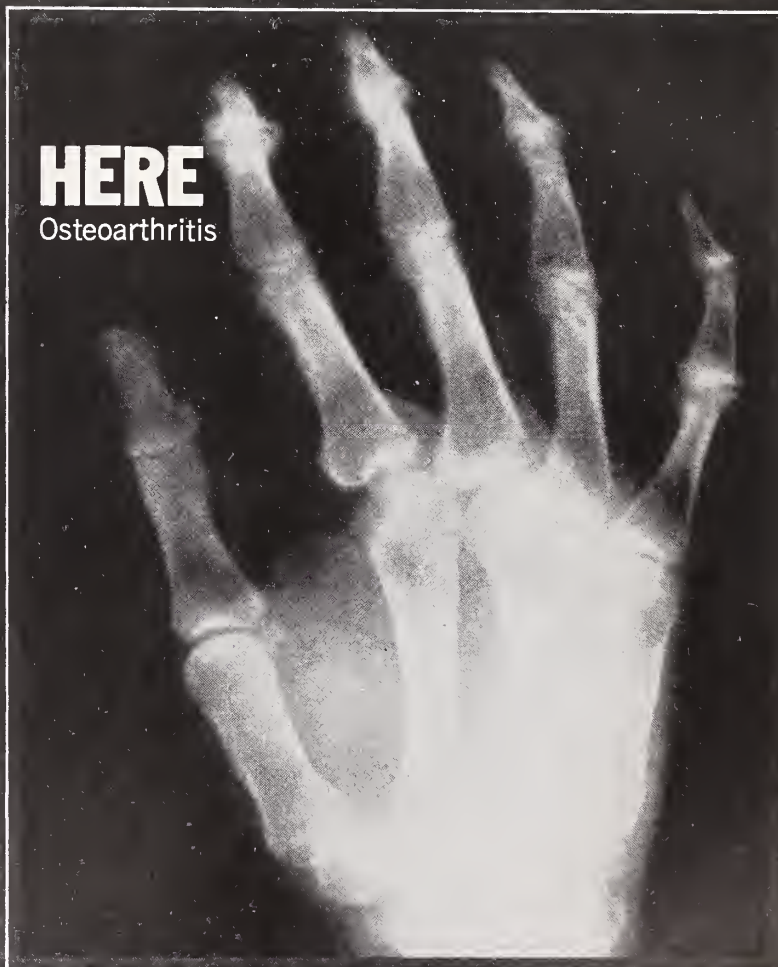


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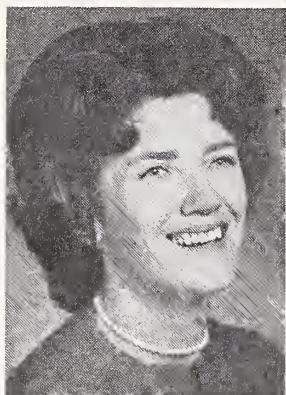
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#4, codeine phosphate\* (64.8 mg.) gr. 1



## *The Woman's Auxiliary* Reports to ISMA

The Woman's Auxiliary to ISMA exists to help carry out the programs of the Association. In order to do this better, the national organization holds workshops for state presidents and presidents-elect and certain officers and chairmen of the state organization. October 7 and 8 Beth Bowen, president-elect, and I were in Chicago to attend the annual Presidents and Presidents-elect Conference.



This year the emphasis was on communication, with a workshop by Mortimer Enright, Director, AMA Speakers and Leadership Program, and T. Stephen May, Ph.D., Associate Professor of Speech, Northwestern University, presenting theories of leadership communication and foot-work drills. Keynote speaker for the conference was Dr. Bergen Evans, Professor of English, Northwestern University, who spoke on "Understanding Misunderstanding." Other highlights of the conference were mini-workshops on international health, health education, health services, health manpower, and some tidbits on report forms and reporting, finance, parliamentary pointers, by-laws and convention planning. Films pertinent to auxiliary programming were shown one evening with discussion following.

October 18-19, the North Central Regional workshops were held in Cincinnati and our state chairman in health education, health services, legislation, membership and AMAERF attended, as well as Beth and I.

The ISMA Convention in Indianapolis was sandwiched in between these two meetings and, unfortunately, I wasn't able to share in all of that. An open Board meeting was held Wednesday, October 10 (all physicians' wives invited), followed by a well-attended legislative luncheon, with Dr. Ned Lamkin speaking on upcoming legislation and some of the threats to medicine's position through both deliberate and undeliberate misunderstanding on the part of newspeople and those arguing for total socialization of medicine. Mike McDermott, Legislative Assistant to ISMA, told us about legislation that will be brought before the Indiana General Assembly.

In addition to these meetings, it has been my privilege to visit many county auxiliaries, attend three district meetings, a health manpower workshop and a conference on the abused and battered child problem. Time goes very quickly and there is always the frustration of not being able to accomplish all one sets out to do.

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With all the problems in the medical field these days, sometimes we forget to express our gratitude to those dedicated men who, day after day, are concerned with the quality of health care for their patients and those others whose diligent research has made it possible to give us hope in this so-called "hopeless" illness. When I hear generalizations made about "those money-hungry doctors who don't care about anybody," I wonder where these men are! Most of the ones I know are very concerned with their patients' welfare and spend many long hours in an office or a hospital when they would rather be home with their families. The Christmas season means different things to all of us because of our different religious and cultural backgrounds but the spirit of loving and giving must be common to all of us; if it is, we can take whatever comes. Happy, happy holidays to all our doctor-husbands!

*Pat Strgsdell*



# County, District News

## Second District

Dr. Robert O. Bethea, Farmersburg, has been chosen as president of the Second District Medical Society, with Dr. J. S. Brown continuing as secretary.

The 1974 annual meeting will be held at Sullivan in June.

## Third District

Election of officers was held at the annual District Meeting on September 25 at the Marriott Resort Center, Clarks-ville, with the following result: Dr. Claude J. Meyer, Jeffersonville, was re-elected president, Dr. Joselito Millan was elected secretary and Dr. Eli Goodman was re-elected to the Board of Trustees.

It was decided to increase District dues to \$10 a year and that the 1974 meeting should be held on a weekend.

## Fourth District

Dr. Kenneth E. Bobb, Seymour, was elected president of the Fourth District Medical Society at the annual meeting.

The position of secretary has not been filled.

## Eighth District

At a meeting on September 18 held in conjunction with the Delaware-Black-ford County Medical Society, the follow-ing officers were elected: President, Dr. Paul W. Sparks, Winchester; secretary, Howard Koch, Winchester. Dr. Jack Alexander, Muncie, was re-elected alter-nate trustee and Dr. Donald Taylor, Muncie, was re-elected to the Blue Shield Board of Directors.

Randolph County will host the 1974 meeting.

## Twelfth District

The following officers were chosen to lead the Twelfth District Medical Society during the current year: President, Dr. Franklin Bryan, Fort Wayne; vice-president, Dr. J. Robert Edwards, Au-burn; secretary-treasurer, Dr. Karl R. Schlademan, Fort Wayne. Dr. John F.

Farquhar, Jr., Fort Wayne, was named Trustee, and Dr. Kenneth Isenogle, also of Fort Wayne, was chosen Blue Shield board member.

One hundred thirty-seven physicians and wives attended the evening dinner to hear Dr. James Sammons, Baytown, Texas, vice chairman of the AMA Board of Trustees, speak on PSRO.

## Thirteenth District

Dr. Jack Hannah, Elkhart, was elected president of the Thirteenth Dis-trict Medical Society at the annual meet-ing on September 12. Dr. John O. Hildebrand, Jr., South Bend, was named president-elect, and Dr. David L. Spald-ing, Mishawaka, was re-elected secretary-treasurer.

Dr. Donald S. Chamberlin, South Bend, was re-elected alternate trustee.

The 1974 meeting was scheduled for September 11 at the Elcona Country Club, Elkhart.

## Bartholomew

New officers of the Bartholomew County Medical Society are: President, Dr. Lindley L. Gammell, Columbus, and secretary, Dr. Robert G. Reed, Jr.

## Boone

Dr. Paul R. Honan has been elected president of the Boone County Medical Society, while Dr. Fuad A. Mukhtar has been elected secretary. Both are of Lebanon.

## Clark

Dr. Ralph Butz, Muncie, was the principal speaker at the first fall meeting of the Clark County Medical Society. He spoke on PRSO, QAP, certification and recertification and utilization review.

Mr. Lorin Marsh, a Muncie lawyer, gave a short talk on the legal aspects of the hospital bylaws and the liabilities of physicians who are members of the medical staff.

## Dearborn-Ohio

Dr. Michael Paris and John O'Bryan spoke on drug abuse and alcoholism at the November meeting of the Dearborn-Ohio Medical Society. Ten members and three guests were present.

The October meeting was the annual meeting with the members of the Auxili-ary and 11 doctors and 11 wives were present. The entertainment was presented by a magician.

## DuBois

Dr. Mell B. Welborn, Evansville, was the speaker at the September meeting of the DuBois County Medical Society. His subject was cardiovascular disease, its diagnosis and surgical treatment.

## Hancock

At the October meeting of the Han-cock County Medical Society a program on clinical hypnosis was given by Mr. Harry Arons. Twenty-eight were in at-tendance.

## Marshall

The September meeting of the Mar-shall County Medical Society was held in conjunction with the 13th Trustee Dis-trict meeting. Governor Otis Bowen was the speaker at the evening banquet.

## Porter

Dr. Ralph O. Butz, Muncie, spoke on PSRO at the September meeting of the Porter County Medical Society, and a Muncie attorney, Mr. Loren Marsh was also a speaker.

## Sullivan

Dr. Robert O. Bethea, Farmersburg, will serve as president of the Sullivan County Medical Society during the cur-rent year. Dr. J. S. Brown will continue to serve as secretary. ◀



# Deaths

## George K. Balsbaugh, M.D.

Dr. George K. Balsbaugh, North Manchester, died October 5 at his home.

He had been a physician for the past 34 years in North Manchester, having graduated from the Indiana University School of Medicine in 1938. He interned at the I.U. Medical Center hospitals.

Dr. Oren served with the Army Medical Corps in World War II, retiring from active duty with the rank of Major.

He was a member of the Wabash County Medical Society and the American Medical Association.

## William F. Oren, M.D.

Dr. William F. Oren, 49, South Bend, died October 18 in his home. He had been a physician-surgeon in South Bend since 1957, having been certified by the American Board of Surgery.

A graduate of the Harvard Medical School, Dr. Oren served his internship at Cook County Hospital, Chicago, with a residency at Peter Bent Brigham Hospital, Boston.

He served in the U. S. Navy in World War II and in the Korean War. In 1962 he began serving as Battalion Surgeon with the 6th Engineering Battalion of the U.S. Marine Corps Reserve.

Dr. Oren was a member of the St. Joseph County Medical Society and of the American Medical Association. He had served on the ISMA Commission on Voluntary Health Agencies from 1963 to 1967.

## Arthur Baptisti, Jr., M.D.

Dr. Arthur Baptisti, Jr., died October 8 after suffering a heart attack while driving near his Brown County home. He was 68.

He had been clinical director in the Department of Obstetrics and Gynecology at the Marion County General Hospital, Indianapolis, since 1958. He also taught at the Indiana University School of Medicine and was a consultant in his specialty for Eli Lilly and Company.

From 1955 through 1958, Dr. Baptisti served both as editor-in-chief of the International Medical Digest and as medical editor for Eli Lilly and Company.

In 1962, 1966 and 1967 he was associated with the hospital ship S. S. HOPE as a visiting professor at South and Central American Universities.

A graduate of the Johns Hopkins Medical School, Dr. Baptisti was a founding Fellow of the American College of Obstetrics and Gynecology and Fellow of the American College of Surgeons and of England's Royal Society of Health. He was a diplomate of the American Board of Obstetrics and Gynecology.

## Theodore N. Siersdorfer, M.D.

Dr. Theodore N. Siersdorfer, Indianapolis, died October 1. He was 96.

A graduate of the Indiana Medical College, the School of Medicine, Purdue University in 1906, Dr. Siersdorfer practiced at Indianapolis and had been a member of the staff of the Methodist Hospital. He obtained his Indiana license in 1918.

He was a member of the Marion County Medical Society and the American Medical Association and was a Senior Member of the Indiana State Medical Association.

## William N. Wishard, Jr.

Dr. William Niles Wishard, Jr., 75, died October 27 in Methodist Hospital, Indianapolis.

A graduate of the Harvard Medical School in 1925, Dr. Wishard practiced at Indianapolis since 1928.

In May 1973 he was awarded the Ramon Guiteras Award at the annual meeting of the American Urological Association at New York City. He was a former president of the North Central Section of the Association.

Dr. Wishard also served at various times as president and executive secretary of the American Board of Urology, Inc.; president of the American Association of Genito-Urinary Surgeons; president of the Marion County Medical Society; president of the medical staff of Methodist Hospital and chairman of the hospital's Professional Standards and Research committees.

He was also a member of the American College of Surgeons, the International Urological Society, the Board of Medical Registration and Examination of Indiana and the American Medical Association. Clinical professor of urology at the I.U. School of Medicine, he was also a member of the board of the Methodist Hospital Foundation. A permanent, endowed professorship was established in his honor at the I.U. School of Medicine in 1969.

Dr. Wishard served on the ISMA Commission on Medical Education and Licensure for a number of years.

## Henry G. Coleman, M.D.

Dr. Henry G. Coleman, 66, Salem, died October 13 at the Washington County Memorial Hospital. He was retired and had lived at Salem since 1958.

A graduate of the Indiana University Medical School in 1934, Dr. Coleman had formerly practiced at Odon. He had served as Washington County Health Officer and as Washington County Coroner. He had also been president of the County Tuberculosis Association for more than 10 years.

During World War II he served with the Army Medical Corps.

He was a member of the Washington County Medical Society and the American Medical Association.



# The Convention Story — 1973



A table by the window on the second floor of the Convention-Exposition Center provides not only a comfortable place to rest and talk but a magnificent view of the Statehouse.



AT the memorial service President Gosman extinguished a candle as the name of each member who died during the past year was read.



THE Registration Desk—with the exhibit hall in the background.





# *The Board of Trustees*



With so many meetings to attend, it seemed the only time the members of the Board of Trustees could get together to check on everything that was going on was at the breakfast, lunch or dinner table.







## *The House of Delegates*







THE Executive Committee—from left to right—Dr. Frank B. Ramsey, Dr. Hugh K. Thatcher, Jr., Mr. James A. Waggener, Dr. Donald Kerr, Dr. James Gosman, Dr. Gilbert Wilhelmus, Dr. Joe Dukes, Dr. Vincent J. Santare.

DR. NAOMI DALTON listens intently to the information provided by the Mead-Johnson representative at that company's booth in the exhibit hall.



THOSE attending the dinner of the women physicians lined up for a photograph with their speakers: Philip Eskew and Patricia Roy of the IHSAA.







## *Reference Committee Meetings*







*More  
Reference  
Committee  
Meetings*







## *Section and Specialty Meetings*







*More Section  
and  
Specialty  
Meetings*







DR. R. LEE WALTON, Marion, received the Mental Health Association in Indiana's 1973 Physician of the Year Award from Governor Matthew Welsh (far left).

JAMES HETHERINGTON, of WR-TV, Indianapolis, receives an award from President Gosman for a documentary on health care costs (right).

GENE POL'CINSKI, of the Chronicle-Tribune, Marion, won an award for a series on the problem of alcoholism (left below).

MRS. LEILA B. HOLMES, of the Indianapolis Star, received a special recognition award for outstanding articles on health and health-related issues.

## Award Winners



WINNERS of Scientific Awards are listed on page 1141, and awards for two of the winners were presented by Dr. Wei-Ping Loh, Gary (left and below).

DR. EVERETT E. BICKERS, Floyds Knobs, received the Community Service Award from Dr. James Gosman.







PAST PRESIDENTS Earl Mericle, Maurice Glock, Kenneth Neumann, Herman Baker, Guy Owsley, Peter Petrich, Patrick J. V. Corcoran and Lowell Steen posed with a past president of the Ohio Medical Association, Dr. Richard L. Fulton, (far right), who was a guest at the Convention.



AMA President-elect Malcolm Todd addressed the House of Delegates.



THE Editorial Board luncheon was attended by (back row) Drs. Samuel Mercer, Alvin Haley, Elton Heaton, Steven Beering, W. P. Loh, (front row) A. W. Cavins, Mrs. Jean Richardson and Dr. Frank B. Ramsey.





GOVERNOR AND MRS. OTIS BOWEN listened attentively to the comments of Mrs. Frank Green, Rushville, before the President's Dinner.

AN overflow crowd was in attendance for the President's Dinner at the Indianapolis Hilton Hotel on Wednesday.



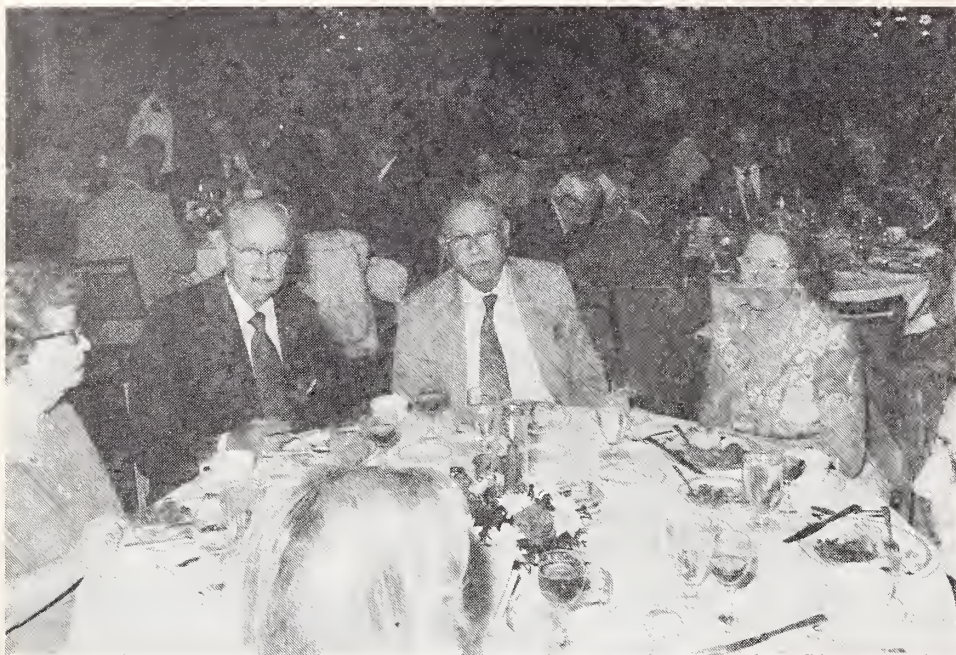




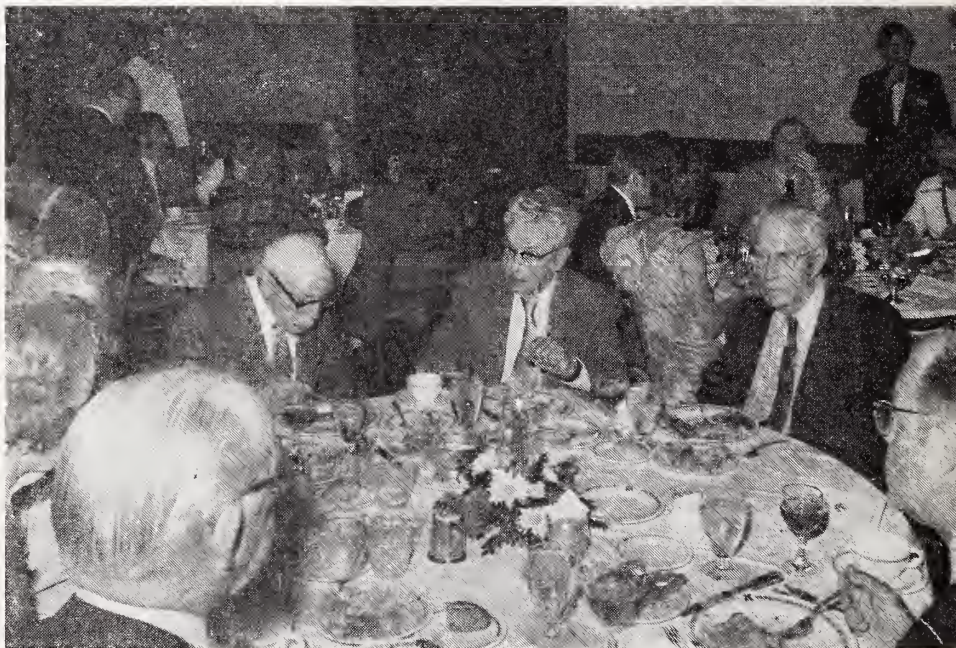
*The Speaker's Table at the President's Dinner.*







NEW MEMBERS of the 50-Year Club were guests at the President's Dinner.





INDIANAPOLIS Mayor Richard Lugar, Congressman William Hudnut, III, and Dr. Fred Smith, Tell City, at the IMPAC luncheon.



OUR new president and president-elect, Drs. Joe Dukes and Gilbert Wilhelmus.



Members of the Philippine Medical Auxiliary prepared a special luncheon for the Women's Auxiliary at the Convention Center.







THE Speakers Table and a view of the crowd in attendance at the PSRO Meeting.



JUDGING the Art and Hobby Exhibit.



DR. JOSEPH E. BALL, Golf Tournament Chairman (left) and Dr. C. Powell Van Meter watch Dr. Wayne H. Thompson practice putting.



MRS. JOSEPH BALL and Mrs. Thomas W. Johnson participated in the tournament and assisted with arrangements.



MRS. OTIS BOWEN was an honor guest at the Women's Prayer Luncheon which happened to occur on the last day of the ISMA Convention and featured a talk by Mrs. Norman Vincent Peale.





# Convention Election Results

## Dr. Gilbert Wilhelmus Named President-Elect

Dr. Gilbert Wilhelmus, Evansville, was elected president-elect of the Indiana State Medical Association at the closing session of the House of Delegates in October. He succeeds Dr. Joe Dukes, Sullivan, who was installed as president on October 11.

(An account of the career and service to organized medicine of Doctor Dukes appeared in the November *Journal*.)

Dr. Hugh K. Thatcher, Jr., Indianapolis, was re-elected treasurer, and Dr. Arvine K. Popplewell, Indianapolis, was re-elected assistant treasurer.

Dr. Vincent J. Santare, Munster, was elected chairman of the Board of Trustees, while Dr. Donald M. Kerr of Bedford was re-elected chairman of the Executive Committee.

Dr. John W. Beeler, Indianapolis, was named to the newly created post of Speaker of the House of Delegates, while Dr. William R. Cast, Fort Wayne, was elected vice speaker of the House.

Dr. John S. Farquhar, Jr., Fort Wayne, was the only new trustee taking office. He succeeds Dr. William R. Clark, Sr., Fort Wayne, who resigned. Dr. Clark was elected to the Executive Committee.

Dr. Bernard Rosenblatt, Evansville, was elected alternate trustee from the First District. Alternate trustees who were re-elected were: Fourth District, Dr. William Blaisdell, Seymour; Fifth District, Dr. William G. Bannon, Terre Haute; Eighth District, Dr. Jack L. Alexander, Muncie; Thirteenth District, Dr. Donald S. Chamberlain, South Bend.

Trustees who were re-elected were: Dr. Eli Goodman, Charlestown; Dr. Paul M. Inlow, Shelbyville, and Dr. William M. Sholty, Lafayette.

Dr. Patrick J. V. Corcoran, Evansville, was elected a delegate to the American Medical Association, and Dr. Lowell H. Steen, Hammond, was re-elected to the post of AMA delegate.

Dr. Thomas C. Tyrrell, Hammond, was re-elected alternate AMA delegate, and Dr. Peter R. Petrich, Attica, was elected alternate delegate.

### New Section Officers

Results of the various Section elections are as follows:

*Section on Surgery:* Chairman, J. Robert Edwards, Auburn; vice chairman, Lowell Hillis, Logansport; secretary, Robert Nagan, Indianapolis.

*Section on Internal Medicine:* Chairman, John L. Ferry, Hammond; vice chairman, Thomas W. Alley, Indianapolis; secretary, Charles W. Magnuson, South Bend.

*Section on Family Physicians:* Chairman, James Daggy, Richmond; vice chairman, David Hadley, Plainfield; secretary, Davis Ellis, Rushville.

*Section on Obstetrics and Gynecology:* Chairman, David E. Copher, Indianapolis; vice chairman, Charles R. Thomas, Indianapolis; secretary, James L. Mount, Bedford.

*Section on Ophthalmology and Otolaryngology:* Chairman, Kenneth Isenogle, Fort Wayne; vice chairman, Wallace Dyer, Evansville; secretary, David Kenney, Indianapolis.

*Section on Anesthesiology:* Chairman, Willis W. Stogsdill, Indianapolis; secretary, David P. Lehman, Kokomo.

*Section on Public Health and Preventive Medicine:* Chairman, Robert M. Seibel, Nashville; vice chairman, Robert C. Speybroeck, South Bend; secretary, David Edwards, Indianapolis.

*Section on Radiology:* Chairman: Dale B. Parshall, Elkhart; vice chairman, James G. Lorman, Fort Wayne; secretary, L. Ray Stewart, Evansville.

*Section on Nervous and Mental Diseases:* Chairman, Wallace R. Van Den Bosch, Lafayette; vice chairman, Gene E. Lynn, Indianapolis; secretary, Richard N. French, Jr., Indianapolis.

*Section on Pathology and Forensic Medicine:* Chairman, Clyde Culbertson, Indianapolis; vice chairman, Wei-Ping Loh, Gary; secretary, Victor Muller, Indianapolis.

*Section on Pediatrics:* Chairman, George F. Parker, Indianapolis; vice chairman, John R. Poncher, Valparaiso; secretary, Robert M. Sweeney, South Bend.

*Section on Directors of Medical Education:* Chairman, Lindley H. Wagner, Lafayette; vice chairman, John Cullison, Muncie; secretary, W. Thomas Spain, Evansville.

*Section on Cutaneous Medicine:* Chairman, Victor C. Hackney, Indianapolis; vice chairman, William B. Moores, Indianapolis; secretary, Emanuel C. Liss, South Bend.

*Section on College Health Physicians:* Chairman, Floyd Thurston, Bloomington; secretary, James R. Greenlee, Bloomington. ◀



# The Winners—124th Annual Convention Indianapolis, October 8-11, 1973

## Art and Hobby Show

### Judge's Selections

#### Division I—Art

\*Best of Show: "L'apres Midi d'un Faun" (acrylic), James M. Donahue, M.D., Indianapolis

Honorable Mention for Best of Show: "Rosebushes with Dewdrops and Butterflies" (watercolor), W. P. Loh, M.D., Gary

#### Section 1

First: "L'apres Midi d'un Faun" (acrylic), James M. Donahue, M.D., Indianapolis

Second: "Harvest Time" (oil), Julieta Higgins, Evansville

Third: "My First" (oil), Chloe Goldsmith, Marion

Honorable Mention: "Reflections" (oil), Mrs. George Teter, Indianapolis

#### Section 2:

First: "Rosebushes with Dewdrops and Butterflies" (watercolor), W. P. Loh, M.D., Gary

Second: "Bouquet from Momma" (watercolor), Jeanne Brubeck, Martinsville & "The Feast" (batik), Jeanne Brubeck, Martinsville

Third: "On the Mall" (Watercolor), James M. Donahue, M.D., Indianapolis & "Red Geraniums" (watercolor & pastel), Jeanne Brubeck, Martinsville

Honorable Mention: "Innocence" (charcoal), Mrs. George Teter, Indianapolis

#### Division II—Photography

\*Best of Show (First): "And How Do You Love?" Robert McAdams, M.D., Lafayette

Honorable Mention for Best of Show (Second): "Lady from Nepal," Leo Kammen, M.D., Indianapolis

Second: "Flower Print (#1)," Truman Caylor, M.D., Bluffton

Third: "Fishing at Sunset," David A. Goldsmith, M.D., Marion

Honorable Mention: "Thomas," Robert E. Hannemann, M.D., West Lafayette & "Churchyard-Santorini," Richard A. Brickley, M.D., Indianapolis

#### Division III—Crafts

\*Best of Show: "Gems of Organic Origin," E. M. Gillum, M.D., Portland

First: "Handbag" (decoupage), Julieta Higgins, Evansville

Second: "Lapidary," Harry W. Garton, M.D., Ft. Wayne

Honorable Mention: "Yellowgreen Sun" (Rya-rug), Kirsten Grosz, Indianapolis, "Hideaway," Ellen Roushdi, Indianapolis & "Roses" (needlepoint), Cathy Siderys, Indianapolis

### Results of Voting

#### Division I—Art

##### Section 1:

First: "Reflections" (oil), Mrs. George Teter, Indianapolis

Second: "Fall Flowers" (oil), Julieta Higgins, Evansville

Third: "Autumn Creek" (oil), Julieta Higgins, Evansville

Honorable Mention: "Kinsfolk" (oil), Mrs. Leon Gray, Martinsville

##### Section 2:

First: "Rosebushes with Dewdrops and Butterflies" (watercolor), W. P. Loh, M.D., Gary

Second: "Swans" (watercolor), W. P. Loh, M.D., Gary

Third: "The Feast" (batik), Jeanne Brubeck, Martinsville

Honorable Mention: "Innocence" (charcoal), Mrs. George Teter, Indianapolis

#### Division II—Photography

First: "And How Do You Love?" Robert McAdams, M.D., Lafayette

Second: "Nocturne," Robert McAdams, M.D., Lafayette

Third: "Lady from Nepal," Leo Kammen, M.D., Indianapolis

Honorable Mention: "Poseidon," Richard A. Brickley, M.D., Indianapolis

#### Division III—Crafts

First: "Gems of Organic Origin," E. M. Gillum, M.D., Portland

Second: "Yellowgreen Sun" (Rya-rug), Kirsten Grosz, Indianapolis

Third: "Handbag" (decoupage), Julieta Higgins, Evansville

Honorable Mention: "Lapidary," Harry W. Garton, M.D., Ft. Wayne

\*Most Original: "Hideaway," Ellen Roushdi, Indianapolis

## Scientific Exhibit Award Winners

First Place: Carotid Stenosis: Surgical and Radiological Evaluation—Austin L. Gardner, M.D., E. C. Wheeler, M.D., and D. R. Elliott, M.D., Indianapolis

Second Place: Trigeminal Neuralgia: A New Surgical Approach—J. M. Tew, Jr., M.D., Cincinnati

Third Place: Diagnosis-Treatment: Acoustic Tumors—J. M. Tew, Jr., M.D., R. Lukin, M.D., and R. J. Wiet, M.D., Cincinnati



# Minutes of the House of Delegates

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# House of Delegates Proceedings

October 8, 10 and 11, 1973  
INDIANAPOLIS SESSION

The first meeting of the House of Delegates convened at 9:30 a.m., Monday, October 8, 1973, in the Ballroom of the Columbia Club, Indianapolis, with Dr. James H. Gosman, president of the Indiana State Medical Association, presiding.

The second meeting of the House was convened at 8:00 a.m., Wednesday, October 10, in Rooms 210-212 of the Indiana Convention-Exposition Center, and the final meeting was held at 9:00 a.m., Thursday, October 11.

## Presenting of Colors

The Paul Coble Post of the American Legion and the Fort Benjamin Harrison Band presented the colors at the first meeting of the House. Duane Compton, D.D.S., Chaplain of the Paul Coble Post gave the invocation.

## In Memoriam

Following is a list of members of the Indiana State Medical Association who were members of the House of Delegates or who served the Association in an official capacity and who have died since the 1972 annual session.

MAX R. ADAMS, Greenfield  
RAY T. BELDING, Indianapolis  
NORMAN R. BOOHER,  
Indianapolis  
JOHN M. BRETZ, Huntingburg  
JESSE E. BURKS,  
formerly Crawfordsville  
STUART R. COMBS, Terre Haute  
N. CORT DAVIDSON,  
Indianapolis  
GEORGE R. DILLINGER,  
formerly French Lick  
JAMES L. DOENGES,  
Anderson  
EVERETT F. DONNELLY,  
South Bend  
PAUL J. FOUTS, Indianapolis  
ROBERT W. GEHRES,  
Shelbyville  
D. RICHARD GILL, Huntington  
MARVIN F. GREIBER, Muncie  
ROBERT G. HARKNESS,  
Terre Haute

EUGENE L. HEDDE,  
Logansport  
PHILIP T. HOLLAND,  
Bloomington  
WM. HARRY HOWARD,  
Munster  
JOHN W. HUMPHREYS,  
Crawfordsville  
WENDELL C. KELLY, Anderson  
JOHN S. KETCHAM, Frankfort  
GERALD J. KOHNE, Decatur  
HEDWIG S. KUHN, Hammond  
HARRY R. KERR, Indianapolis  
JAMES G. KIDD,  
North Manchester  
PAUL T. LAMEY, Anderson  
CHARLES F. LEICH, Evansville  
ROBERT E. LYONS,  
Bloomington  
CHARLES B. NASH,  
formerly Valparaiso  
ANNE S. NICHOLS, Greencastle  
GLYNN A. RIVERS, Muncie  
ARTHUR J. ROSER, Fort Wayne  
VERNE L. TURLEY, Fowler  
JAMES B. WRAY, Indianapolis  
PHILIP E. YUNKER, Howe

## Report of Credentials Committee

Dr. Robert Seibel, chairman of the Credentials Committee, reported 101 delegates, 8 alternate delegates, 4 officers, 12 trustees, 2 alternate trustees and 10 past presidents in attendance at the first meeting. The chair announced that, inasmuch as 50 constitutes a quorum, there was a quorum present for the first session of the House of Delegates. Attendance at the second meeting was 88 delegates, 9 alternate delegates, 4 officers, 13 trustees, 2 alternate trustees and 7 past presidents. At the last meeting the attendance was 100 delegates, 9 alternate delegates, 14 trustees, 2 alternate trustees and 7 past presidents.

Doctor Gosman announced that Dr. Lester H. Hoyt, Indianapolis, would serve as parliamentarian.

## Approval of Minutes

The proceedings of the 123rd annual

meeting of the House of Delegates held in Indianapolis, Indiana, and published in the December 1973 JOURNAL, of the Indiana State Medical Association were approved upon motion duly made, seconded and carried.

## Introduction of Guests

The president introduced Dr. Malcolm Todd, president-elect of the AMA, (Doctor Todd spoke to the delegates at the second meeting); Dr. Richard L. Fulton, past president of the Ohio State Medical Association; Dr. Fred C. Rainey, president, Kentucky Medical Association; Dr. Gerald J. Derus, president, State Medical Society of Wisconsin; Mr. Schuyler K. Geller, president of the Indiana Chapter of Student AMA, and Forrest Paul, D.D.S., member of the Paul Coble Post of the American Legion.

## Address of the President

### HOUSE ACTION: Ordered filed

I have never been convinced that the medicine or the science on which it is based needs a revolution to progress. There are many things indicating all is not well. I view with trepidation the steady encroachment of government, highlighted by such schemes as national health insurance and others.

Failure to deliver enough medical care to the needy and ineffective efforts to keep medical costs under control are not encouraging; its strong leadership is no longer regarded as essential. There is a trend among young physicians who demand and get large incomes for too little work, and the failure to give of themselves to make life a little easier for the sick. Pride in our profession has slipped to a dangerously low level. But, most important, while we have many vocal and effective complainers, there have been far too few forward-looking thinkers with constructive and creative remedies to offer.

My point is—that we have lost an infinitely precious thing in abandoning the transcendent or divine aspects of medicine. Or did we not have as our first hospital, a temple? Belief in divinity gave people faith in themselves; faith in nature was not capricious and faith that there was purpose in responsibility in life. Of these, character is constituted, along with the fuller life created by art and literature. We have voluntarily cut our ties with this source. We physicians have failed to the degree that we are unwilling, or are unable, by teaching or precept, to inculcate any awareness of



the material world as has always been a part of our cultural heritage.

With death as seen as the friend of the elderly, the purveyor of eternal sleep, the merging of individuals with the universal consciousness, or whether there is truly no death, only transfiguration—all our beliefs are defensible and forever unprovable. Thus, make no mistake about it, religious or quasi-religious belief has deeply affected the influence of medicine. This, I fear, we have forgotten.

The next major problem is what I like to think of as creeping federalism—the gradual encroachment of government on our lives. In my lifetime the speed up of the movement down this treacherous road has been phenomenal. Most physicians would need no convincing. But far too many of them acquiesce to the movement, oblivious to the long-term effects. Government rarely subsidizes freedom. I want individual responsibility although this is not to say that the government need not play a carefully conceived and defined part. We say the individual as our society, in our society, is paramount but do not act accordingly. We seem to invariably want a law to force us to do something we ought to do ourselves and then complain whether it is or is not enforced. We have consciously and unconsciously implanted into people's minds the idea that they have rights unlimited and that government is the provider of these rights. Conveniently, the responsibilities connected with these rights are forgotten. If money were to be supplied to fulfill all the rights people are being taught to demand, there would never be enough. I do not believe taxpayers' money should be offered as pay to allow government to dictate how the practice of medicine is to be organized, for it has been amply demonstrated that physicians are able, if not always willing, to fashion their ways of practice and remain solvent and, even more importantly, free.

Proliferating government agencies have become the chief offenders. The commissions, coordinators, interrogators, planners, statisticians, economists and others are taking over the conduct of medical research with the skillful and subtle connivance of those physicians who are politically oriented.

The third problem concerns ourselves. I do not believe that we, or the generation now taking over, lack conscience or responsibility. They are simply not used enough. Physicians are beginning to suffer to some degree from over-emphasis on rights. When you voluntarily enter

medicine you know that the needs of the patient are supreme. Unionizing, strikes for pay raises, arrogant self advertising and unwillingness to listen to criticism have demeaned us all. We have been too tolerant of those among us who have become careless.

We do not do a good job of teaching the social, legal, and legislative aspects of medicine. Few physicians are fully in command of the facts on the issues related to medicine that concern the public and legislators. The truth about organized medicine is almost never made a part of the medical curriculum. Too often we express our views in public irresponsibly. But for those among us who fear we are the worst offenders, take heart by listening to the free-swinging charlatanism and morosity of the average television or radio talk show, or so-called panel discussion. These are all really correctable faults.

Most important is the failure of physicians to think deeply about our manifold problems. True, we need to know the evidence, but we must not stop there. Dealing with what appear to be impractical abstractions and philosophical concepts have never had much appeal. But the longer we live with the problems of ethics, personal identity, freedom, purpose and belief, the greater seem their importance. These fundamentals provide the ultimate standard on which to assess the merit of change. When we decide to embark on the revolutionary way of practice or a new policy for the conduct of research, we had better understand the underlying philosophy.

Be reminded that trivial misbehavior or lack of consideration can often lead to results of important philosophical implications. Thus, respect given to a physician must be earned. It is not self-perpetuating. Loss of respect leads to a lack of patient confidence, dissatisfaction and exaggerated criticism expressing unwillingness to vote against socialization of medicine.

Unless some lead in the fight to maintain individual responsibility and convince the voters that this is to their ultimate advantage, the voters will continue to listen and agree with the vocal, the violent and articulate minority who would lead them into a police state conveniently labeled "utopian democracy"—too often enforced by the slaughter of millions.

Physicians must learn the price of short-term gains in terms of long-term prices. The only way to do this is never to lose sight of the underlying philosophy, abstract and often remote as it may

seem. Others cannot do this for us. We would court even further disaster were we to surrender decision-making to a federal government already so overburdened that decisions on the military, foreign policy, currency, and welfare, to mention but a few problems, leave so much to be desired. We need a rebirth of those things that have traditionally made medicine great.

American medicine achieved its present distinction by raising the standards of medical education, step by step, to improve personnel and research facilities. At the present time every medical school and research institute is confronted with the threat of sharp cutbacks, even extinction, because of economic pressures over which they have no control. The basic tenet of the Hippocratic doctrine urges physicians "to hold fast to that which is good." The threat to destroy what good we have may be the nearest crisis with which medicine must deal.

And so, with these protracted and controversial suggestions, I will now relegate myself to the archives where, in time, and only then, can one really be judged.

I am grateful indeed for the honor of having served as president of the Indiana State Medical Association for the past year.

## Printed Report of the President

**HOUSE ACTION:** Report filed with the following recommendations adopted:

- (a) Review of the structure of the Committees and Commissions with the recommendation it be referred to the Commission on Constitution and Bylaws as well as the Commission on Special Activities with the intent of a joint meeting later to work out changes, if this be their conclusion.
- (b) Special attention given to the activities of the Building Committee.
- (c) Personal appreciation for the efforts exerted by Dr. Glen McClure and the Commission on Convention Arrangements.
- (d) Urges continued interest in the Indiana Medical History Foundation.

In attempting to finalize the activities of your President during the past year, and make suggestions for the future, I find many ideas seeking expression. Yet, thoughts of those on the books for your immediate consideration at this House of Delegates seem to take precedence.

When I assumed the duties as your President, I pledged to support those



concepts forwarded by our immediate past president, and attempt to lay the seeds for future study and thought for the future. I hope I have at least succeeded to that degree. In my opening statements last year, I made a plea for unity. All my efforts have been directed toward that purpose. Need for unity is even more paramount today. At that same time, I listed five areas which I felt were most in the need of attention. These five areas were:

1. Distribution of physicians in medical care in rural and urban areas.
2. Public relations and communications with grass-roots, public and physician.
3. Problems surrounding third party insurance companies.
4. Medical liability.
5. Cost of medical care along with quality of medical care.

It has been my ambition to visit with as many county societies, districts, committee and commission meetings as I could. The reception at all of these meetings has been most gratifying. We also attempted to meet with and attend annual gatherings of all allied health organizations we could. We further attempted to be present at many legislative committee sessions, when needed, to present Medicine's point of view, and help inform our legislators on the facts, so that they could make their judgments. We attempted to involve and co-operate more with the I.U. School of Medicine and faculty, the medical students, and intern resident staffs. A membership drive was initiated under the chairmanship of Dr. Peter Petrich. Figures as of July 31, 1973, shows an increase of 99 ISMA members and 113 AMA members. A medical liability study was undertaken and is being pursued at this writing. A Joint Practice Commission with the Indiana State Nursing Association has been recommended through the Interprofessional Relations Committee to survey the entire relationship between physicians and nurses. Additional expansion to involve relationship of medical staff and administration in hospitals and legislation is planned. The Governor's Conference on Emergency Medical Services, initiated through the joint efforts of the Commission on Emergency Medical Services along with co-operation of Regional Medical Program, Indiana Hospital Association, and others, appears to have been a huge success and a giant step forward toward making this important facet a reality.

Our Commission on Aging has done a yeoman's job of establishing a better

relationship and understanding with those involved with Medicaid and Medicare patients. Rest assured the many gripes and problems we all have with certification and recertification, payments, intermediary, letters to patients, were all discussed directly with the involved parties, and, in my opinion, progress is being made to relieve the physicians of the many annoying day-in and day-out frustrations.

Our Woman's Auxiliary has responded beautifully to my request for members from their organization to serve on our committees and commissions, and their input has been greatly appreciated. It is my hope that, through their attendance, these ladies can carry back to the Auxiliary what is taking place in the many areas of concern. My sincere thanks to Mrs. Smith of Fort Wayne and Mrs. Stogsdill of Indianapolis for their co-operation.

We heard many fine comments regarding the conference of county officers held this year. The speakers were excellent, and the material covered very timely.

It is my opinion that much has been accomplished in the area of rural health through our Special Activities Commission (sub-committee on rural health), the student-faculty ISMA retreat, and the development of an Assessment Committee to help evaluate those areas requesting physicians.

Nothing could be accomplished without the exceedingly fine, dedicated Headquarters Staff. When I review the figures of numbers of employees of other states of similar size as ours, and see what we have accomplished, I can only be proud. Mr. Jim Waggener's ability and dedication cannot be challenged, for wherever I traveled to other states, he is known, respected, and, if not present, they inquire about him. Mr. Ken Bush is likewise always present, and always willing to assist with his multitude of responsibilities. Mr. Grindstaff and Mr. Amick, the field men, saved me many hours and lots of energy by chauffeuring me to distant areas of this state. This, of course, was in addition to their expected duties. My personal thanks to each and every one of our fine dedicated ladies who work for us at ISMA Headquarters. Never did I have to ask twice for assistance or wait long for whatever I had requested. Mr. Mike McDermott, the most recent addition to our staff, has demonstrated what can be accomplished by know-how, research, and summarizing into understandable format.

The Historical Medical Museum Committee has been appointed and association with the Indiana Historical Society has been accomplished. We must continue our interest in this fine project because I see a real value for its future. I would suggest you take time to visit the museum, which is located on the Indiana Central State Hospital grounds.

The Tel-Med operation for public information has exceeded our original expectations. It is suggested continuing study be made to enhance the tape library and the extension of its scope to other areas of the state. The Committee on Perinatal Health has been working and planning on very exciting recommendations for a system of maternal and neonatal care that will enable every mother and newborn to receive optimum care consistent with today's knowledge. It is my suggestion that work be encouraged, in that greater involvement in the community hospitals and personnel be a substantial part of their deliberations. The Committee, head by Dr. Sprague Gardiner, is adamant that this program, when activated, be a program of the Indiana State Medical Association, and I agree with that desire. Their recommendations may soon be ready to present to us for consideration.

For future consideration I would suggest the following:

1. It is very obvious that we need additional space at headquarters to carry out the present work load, and for expansion on additional anticipated activities. Because of the continuing educational program, the assessment program, the possible PSRO central activities, the increased use of the ISMA building for meetings, the possibility of having adequate space to hold our House of Delegates' meetings, (see consideration for convention planning below) and other contemplated activities, the Building Committee will have to continue their deliberations for the expansion.

2. With the above considerations added to many others, it is therefore incumbent upon us to enlarge the number of office personnel to adequately carry-out these increased activities. It is my observation that a great deal of time could be saved by our committees and commissions if we had the personnel to do more research into problems facing the profession and to anticipate problems that we may be called upon to instigate or defend.

3. As regards the committees and commissions, there have been increased activities in all of these areas. I know because I have attended most of them.



One cannot praise these hard-working, dedicated members enough. Read their reports, and remember that many man-hours have been devoted to their conclusions. This House of Delegates should study their reports and, I hope, help support them. The Public Information Commission is most anxious to gain approval for their speakers bureau concept. I would recommend to this House of Delegates that we somehow give it at least a two-year trial.

4. We did not accomplish the review of our committees and commissions, as recommended by Dr. Peter Petrich, so I would recommend this item be again referred to the Commission on Constitution and Bylaws as well as the Commission on Special Activities, with the intent of a joint meeting later to work out change, if this be their conclusion.

5. The office of president of this Association has become a burdensome one. Perhaps it was only the added involvement of Public Law 92-603, or of my personal intense desire to do the tasks as I interpreted them. There will be some relief in sight by the establishment of a Speaker and a Vice Speaker of the House of Delegates, and by giving the immediate past president added responsibility. Other state associations have somewhat variable approaches, such as; Illinois provides that the Chairman of the Board runs the many details of the ISMA office, giving the President more freedom for travel, especially within the state. Other states have their immediate past president become chairman of the Board. This latter concept does have some value. I do believe many of our societies were extremely grateful that their State President did show-up and I do believe that a feeling of belonging, "and being interested" was a result of these visits. I would like to suggest the Commission on Constitution and Bylaws review the mechanism employed in other states to determine if Indiana might benefit from a new concept. I was particularly fortunate to have my residence in Indianapolis, which made it a lot easier to attend as many of the meetings as I did. Living at a distance from the Headquarters can be a backbreaker.

6. I must commend the Committee on Convention Arrangements, chaired by Dr. Glen McClure, for a difficult task well done. Although we are two months away from the Convention at the time of this writing, the schedule is rather firm, and it does look good. The specialty societies have done an excellent job of co-operation in preparing their Scientific program. The Dean of I.U.

School of Medicine has given us his support, by making it possible for students to attend at least portions of the program.

7. We must again, however, give consideration regarding change in convention proceedings. I have already stated that in enlarging our building we must give thought to holding our annual House of Delegates' meetings there. Cost, loss of revenue from exhibitors, are prime reasons for this review. In addition, the continuing educational program may be aided and local and regional pride enhanced if the scientific portions of our program (in total or in part) were held in various locations in our state. It is recommended this idea be referred to Convention Arrangements and Future Planning Commissions for their deliberation and suggestions.

8. All studies done to date indicate there is a swing toward family practice interest in our student body. The number of applications for Resident training in family practice has definitely increased. We must not let this interest subside. The problem revolves around adequate funding of training and approved residencies. I recommend we approve the greater involvement of small community hospitals from approved satellite residency programs; we continue to introduce legislation to secure funding and we utilize our association in approaching foundations for funding. While on the subject of post-graduate training, I would like for our House of Delegates to go on record as being against the complete dissolution of the Rotating Intern Program.

9. Anyone who knows of my interests knows that I have been deeply interested in the use of computers in medicine. I, too, as your immediate past president suggested, would advocate and hope for the ISMA to take steps for involvement in installation within the confines of the state office of a computer processing program. There are innumerable uses of such computers that would be of direct service to all the physicians of the state. We have amongst us some of the most knowledgeable people in the field for the necessary expertise.

10. PSRO. Perhaps I should stop right there. So much has been said pro and con; so much money and time has already been spent. It is up to this House of Delegates to decide the direction our ISMA will take.

I do not want any remarks I make to be interpreted as trying to influence

your decision. I simply wish to state what we have been doing in studying the problem, in preparation for putting into operation, and two or three suggestions, should this House of Delegates rule we proceed.

We have investigated the organizational structure, the mechanisms, the parameters, and computerization of many states. I believe we have some advantage here, in that we will be able to utilize the good and throw out the mistakes of others. What I am trying to relate is that we have not been sitting on our hands—we have attempted to be ready.

My suggestions are the following:

1. That we adhere to the statewide concept of the PSRO with sub-contracting to regional ongoing review mechanisms. The regions to be decided by you on a sensible unity-of-purpose structure. I urge that we not split ourselves in our thinking. Review would still be done locally as it is now being accomplished.

2. That our Specialty Sections decide on the parameters then adjust them to meet the individual regional desires, and customary provisions of care.

3. The doctor, in alliance with the other health professionals, must lead the way in establishing his own data processing facilities. He must begin to be informed as to the proper use and the potential misuse of this kind of material. Accomplishing this end will require the utilization of data processing expertise responsible to him, and to him alone. Almost any hospital or institution with a computer would be happy to offset some of their fixed expenses by modifying their claims-processing programs to such use. We must build in restraints as to the use of this data before we yield it to any agency. Once the public understands it, they will support our position on this.

4. Guidelines and regulations have not been promulgated at this time. We should, therefore, reserve the opinion of withdrawing, if it is felt that the regulations put into effect may be in any way detrimental to the provisions of good medical care at a reasonable cost.

Many of the suggestions I made before this House of Delegates last year will be up for your consideration this year. I urge the membership to act in favor of them. Other suggestions made at this time are still under study, or are not ready for action at this House of Delegates.



Thank you for the opportunity to serve this great Association and profession. I can only hope that I have represented you well, and within the standards of your wishes.

Remarks of President Gosman

Any delegate may introduce a resolution from the floor provided that where a resolution has been first submitted to the Committee on Rules and Order of Business together with a written statement setting forth the reasons why said resolution was not mailed to the Executive Secretary more than 45 days prior to the meeting of the House of Delegates and also setting forth in said written statement the reason why said resolution is of such an emergency nature that it cannot wait until the next meeting of the House, and that said Committee on Rules and Order of Business has approved said resolution for submission to the House, and that each delegate shall be furnished a copy before the next meeting of the House, then this subsection of the Bylaws may be suspended with respect to said resolution upon a two-thirds vote of the House of Delegates.

Committee on Rules and Order of Business is in session in the Foyer of the Ballroom.

Appointment of Reference Committees

In accordance with the Bylaws, I have appointed reference committees, and the names of the members of these committees are published in the Handbook.

These reference committees are to serve during this annual convention only and should not be confused with the commissions or standing committees of this Association.

To these reference committees will be referred all reports, resolutions and measures presented to the House of Delegates at this session, except such matters as properly come before the Board and the recommendations of these committees shall be submitted at the second meeting of the House of Delegates at 8:00 a.m., Wednesday, October 10, for acceptance in the original or modified form, or for rejection. The Wednesday morning meeting will be held in Room 210-212 of the Convention Center.

Each reference committee consists of at least five members; the first member named is chairman. Will committee members please stand as their names are called?

REFERENCE COMMITTEE NO. 1

- Thomas C. Tyrrell, Hammond (Lake),  
*Chairman*
- Robert N. McCallum, Indianapolis  
(Marion)
- Thomas Shields, Richmond (Wayne)
- Donald G. Mason, Angola (Steuben)
- William F. Kerrigan, Connersville (Fayette-Franklin)
- Albert S. Ritz, Evansville (Vanderburgh)

REFERENCE COMMITTEE NO. 2

- Malcolm L. Wrege, Indianapolis  
(Marion), *Chairman*
- George M. Haley, South Bend  
(St. Joseph)
- Daniel C. Drew, Jasper (Dubois)
- George M. Underwood, Lafayette  
(Tippecanoe)
- Lloyd L. Hill, Peru (Miami)

REFERENCE COMMITTEE NO. 3

- Albert M. Donato, Indianapolis  
(Marion), *Chairman*
- Norman E. Beaver, Berne (Adams)
- Guy B. Ingwell, Knox (Starke)
- T. Neal Petry, Delphi (Carroll)
- Forest Radcliff, Evansville (Vanderburgh)
- Fred C. Haggerty, Greencastle (Putnam)

REFERENCE COMMITTEE NO. 4

- Ross L. Egger, Daleville (Delaware-Blackford), *Chairman*
- William R. Cast, Fort Wayne (Allen)
- Max N. Hoffman, Covington  
(Fountain-Warren)
- John W. Beeler, Indianapolis (Marion)
- Theodore R. Espy, Gary (Lake)
- Robert H. Ward, Tell City (Perry)

REFERENCE COMMITTEE NO. 5

- William G. Bannon, Terre Haute (Vigo)  
*Chairman*
- Gerald R. Bougher, Monticello (White)
- E. Henry Lamkin, Indianapolis (Marion)
- Leonard W. Neal, Munster (Lake)
- Bernard B. Rosenblatt, Evansville  
(Vanderburgh)
- Ralph O. Smith, Vincennes (Knox)
- Everett E. Bickers, Floyds Knobs  
(Floyd)
- Lee H. Trachtenberg, Munster (Lake)

CREDENTIALS COMMITTEE

- Robert M. Seibel, Nashville  
(Bartholomew-Brown), *Chairman*
- John C. Harvey, Auburn (DeKalb)
- Robert H. Rang, Washington  
(Daviess-Martin)

- M. S. Mount, Bloomfield (Greene)
- Jack W. Higgins, Kokomo (Howard)

TELLERS

- James S. Fitzpatrick, Portland (Jay)
- Lawrence E. Allen, Anderson  
(Madison)
- Lowell R. Steele, Mooresville (Morgan)
- William R. Anderson, Bloomington  
(Owen-Monroe)

AMA Delegates and Alternate Delegates

The following were elected to a two-year term as delegate and alternate delegate to the American Medical Association, their terms to expire December 31, 1975.

Delegate, Patrick J. V. Corcoran, Evansville; alternate, Peter R. Petrich, Attica; delegate, Lowell H. Steen, Hammond; alternate, Thomas C. Tyrrell, Hammond

Resolution Concerning Jack Shields, M.D.

HOUSE ACTION: Adopted by standing vote

On behalf of the House, The Board of Trustees, and all members of ISMA, we wish to go on record to commend Dr. Jack Shields of Brownstown for his years of service to organized medicine. During his active years Jack has been a leader in his community (church, school and politics). Active as a trustee of his hospital, and in service to his local medical society, district society, and Indiana State Medical Association. This House in its wisdom has sent Jack to represent us at the American Medical Association where he has served with distinction. His ability to get young physicians involved in organized medicine is well known and his trustee retirement clearly testifies to his interest.

One cannot give praise to Jack without including his wife, Bea, who has served the Auxiliary both on a local level and as state president. For this the House wishes to commend and thank Bea.

Therefore, Be It Resolved, that this House go on record to commend and spread upon its minutes the sincere thanks of organized medicine, as well as that of every physician of Indiana, for the service of Dr. Jack Shields to his fellowman.



## Selection of City for 1978 Meeting

It was moved, seconded and carried to hold the 1978 meeting in French Lick, the week of October 14-19.

Dr. Charles McCalla made a motion to hold the 1974 meeting in French Lick. Dr. Hugh Thatcher amended the motion to have the 1974 meeting in Indianapolis, as it is the 125th anniversary of the Association and it would be desirable to have as many members as possible in attendance for the anniversary meeting. Dr. Bernard Kemker amended the amendment by stating the 1975 meeting would be held in French Lick. This was seconded and carried. The dates for the 1975 meeting are October 18-23.

## Amendments to the Constitution

### HOUSE ACTION: Adopted.

Be It Resolved that Article IV, Section 1, be amended by striking the entire Section 1 as now printed and substituting the following:

Section 1. This Association shall consist of Active Members, Associate Members, Senior Members, Honorary Members, Disabled Members and Distinguished Members.

Be It Resolved that Article IV, Section 3, be amended by inserting a period after the word "Association" and striking the balance of the sentence. Section 3 will then read:

Section 3. Interns and Residents. Interns and Residents who hold membership in the Indiana State Medical Association shall have all the rights and privileges of this Association.

Be It Resolved that Section 5 of Article IV of the Constitution be amended by striking the entire Section as now printed and substituting the following:

Section 5. Senior Members. Senior Members shall be physicians of the state of Indiana who have attained the age of 70 years and have held membership in the Indiana State Medical Association for 20 years or more; or who have held membership in the Indiana State Medical Association or in some one or more other like state organization which is a component state organization of the American Medical Association, for a combined total of 20 years or more, and who, upon their application, have been certified to the Executive Secretary as eligible for such membership by the county societies of which they are members. It shall be the duty of the county

medical society to verify, through the office or offices of any other state organization or organizations, the fact of membership therein when such membership is claimed as part compliance with the eligibility requirement of 20 years of membership.

Be It Resolved that Article IV, Section 7 be renumbered as Section 8 and a new Section 7 be substituted to read as follows:

Section 7. Distinguished Members. Active Members who have fulfilled the American Medical Association's Physician Recognition Award requirements of 150 hours for three years of continuing medical education as a minimum shall be designated as Distinguished Members.

Be It Resolved that Article V be amended to read as follows:

Section 1. The House of Delegates shall be the legislative and business body of the Association and shall consist of (1) Delegates, or their designated alternates, elected by the component county societies; (2) the Trustees, or their designated alternates, and (3) the ex-presidents of the Indiana State Medical Association. The delegate or their designated alternate delegate elected by their respective Section shall also be a member but without the power to vote. The following shall be ex officio members: the President, the President-elect, the Executive Secretary, the Treasurer and Assistant Treasurer of this Association, the Speaker, the Vice-Speaker and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the President or person presiding shall cast the deciding vote.

Section 2. The Speaker of the House of Delegates shall preside at all meetings. He shall be elected annually from the membership of the House. Ex officio, the Speaker shall be a member of all Commissions and Committees and the Board of Trustees of this Association without the power to vote. Training in parliamentary procedure shall be mandatory for the Speaker and shall be provided at the expense of the Association.

Section 3. The Vice-Speaker of the House of Delegates shall preside at meetings in the absence of the Speaker or at the request of the Speaker. The Vice-Speaker shall be elected annually from the membership of the House. Ex officio, he shall be a member of all Commissions and Committees and the Board of Trustees of this Association without the power to vote. Training in parliamentary procedure shall be mandatory for the Vice-Speaker and shall be

provided at the expense of the Association. In the event the Speaker dies or resigns while in office, the Vice-Speaker shall assume the role of Speaker for the unexpired term.

Section 4. All sessions of the House of Delegates shall be open to all members in good standing of this Association for observation.

Be It Resolved that Article VI be amended by adding the words "immediate past president" following the word "Treasurer," and also by striking the word "and" after the word "vote" and before the word "assistant" and inserting a comma in lieu thereof, and by striking the period after the word "absent" and substituting the following: ", and the Speaker and Vice-Speaker without power to vote." Article VI would then read as follows:

The Board of Trustees shall consist of (1) the Trustees with power to vote and their duly elected alternates, each of the latter without power to vote except in the absence of his Trustee; and (2) ex officio, the President, President-elect, Treasurer, Immediate Past President, with power to vote, Assistant Treasurer without power to vote except in case the Treasurer be absent, and the Speaker and Vice-Speaker without power to vote. Besides its duties mentioned in the Bylaws, the Board of Trustees shall have full charge and control of all the property of the Association. It shall have full authority and power of the House of Delegates between sessions of the House of Delegates, except that it shall not make changes in the laws governing the Association nor exercise legislative functions, except as stated in the Bylaws, and at all times shall be the finance committee of the Association. A majority of elected Trustees shall constitute a quorum.

In line with the above-proposed amendment, it would also be necessary to amend Article IX, Section 1, by inserting after the word "President-elect" and before the word "an" the words "the immediate past president, and also by inserting the words ", a Speaker, a Vice-Speaker" after the words "assistant treasurer." Article IX, Section 1, would then read as follows:

Section 1. The officers of this Association shall be a President, a President-elect, the Immediate Past President, an Executive Secretary, a Treasurer, an Assistant Treasurer, a Speaker, a Vice-Speaker, and the Trustees, each of whom shall be a member, except the Executive Secretary, who need not necessarily be either a physician or a member.



## Election of Officers

**OFFICERS:** Dr. Joe Dukes of Dugger assumed the office of president and Dr. Gilbert M. Wilhelmus of Evansville, was elected president-elect.

Dr. Hugh K. Thatcher, Jr., Indianapolis, was re-elected treasurer by acclamation.

Dr. Arvine G. Popplewell, Indianapolis, was re-elected assistant-treasurer by acclamation.

Dr. Vincent J. Santare, Munster, was elected chairman of the Board of Trustees. Dr. Donald M. Kerr, Bedford, was re-elected chairman of the Executive Committee and Dr. William R. Clark, Fort Wayne, was elected a member of the Executive Committee.

## Election of Trustees

Dr. John S. Farquhar, Jr., Fort Wayne, was elected a new trustee for the Twelfth District in 1973. Three trustees re-elected in 1973 were: Dr. Eli Goodman, Charlestown, Third District; Dr. Paul M. Inlow, Shelbyville, Sixth District and Dr. William M. Sholty, Lafayette, Ninth District.

Dr. Bernard B. Rosenblatt, Evansville, was elected in 1973 alternate trustee for the First District. Four alternate trustees re-elected in 1973 were: Dr. William Blaisdell, Seymour, Fourth District; Dr. William G. Bannon, Terre Haute, Fifth District; Dr. Jack L. Alexander, Muncie, Eighth District and Dr. Donald S. Chamberlain, South Bend, Thirteenth District.

## Address of President-Elect Joe Dukes

### HOUSE ACTION: Ordered filed.

As I look forward to my year as president of the Indiana State Medical Association, one thought occurs to me as a point of personal philosophy which I will attempt to adhere to during my tenure—that thought is to make as few changes in the structure of organized medicine in Indiana and its current programs as possible. The term for all of this is preservation of “status quo.”

Some may look upon this as a non-progressive attitude but, in view of the fact organized medicine each day has to face a new concept in the delivery of medical care which is imposed upon the profession by others than members of our own profession, maintaining the “status quo” in reality offers a serious challenge.

It is my contention that during the next year and distant future, organized medicine and the individual physician will be compelled to contend with legislators, consumers and other so-called experts outside the medical professions attempting to dictate what is best for our patients. These experts are proceeding on courses which we as a profession have, in the most part, found to be completely alien to the best interests of medical care delivery.

Recently a featured columnist in the Indianapolis Star, Max Lerner, in an article entitled “An Open Letter to the Graduates” said this: “It has been a hard road we have traveled during the past decade marked by skyrocketing technology, a hectic economy, a turn-about in foreign policy, turmoil in the inner cities and on campuses, the erosion of authority, the alienations and uprootings, the loosening of ties, the breaking of connections, the passionate movements of ethnics and women’s liberation, transformation of codes and attitudes, the generational distance, changes in consciousness, and the challenge to lifestyles and value systems.”

Maintaining this status quo, I feel is necessary at this time in the interest of restoring sensibility to the maddening and accelerated pace which is generating and which, in my estimation, is not in the best interest of a healthy society and the medical profession’s future.

As I prepare this report, we are all aware of the concepts of Professional Standards Review Organizations which are now being imposed on the profession by the Federal government. Where we are going with this, and what is going to happen, I personally cannot foresee; but in another sense I think that what has happened in the past with Medicare and Medicaid and what seems obviously to be occurring in the growing trend toward a national health insurance program simply is a forecast of what is going to continue to occur, and I believe there will be additional efforts by government and outside groups to harness and control the activities of organized medicine and the individual physician.

Among some of the matters which occur to me at this time which should be given close attention during the next year is the continuing effort to establish closer working ties with physician-members of the Blue Cross and Blue Shield Boards. We have found during the past year that they are interested in knowing of the policies of the Indiana State Medical Association and during my term I will make every effort to see that

better communication between the board and the Indiana State Medical Association and these two groups becomes more intensified.

Another area which I believe needs full attention is closer relationships with our medical student body at the Indiana University School of Medicine and the intern and resident groups. They have indicated a desire to know more about the actual practice of medicine and Indiana areas wanting physicians. In order to create more interest in the young doctors who will be practicing in the future, we must make more deliberate efforts to bring them into the fold of organized medicine. Someone once said “what you are in on, you are not down on” and this will be the policy which I will encourage in an effort to communicate and join in deliberation on some of the issues with these young people.

Another successful program in which we will make an effort to incorporate some extensions will be in the Tel-Med public relations and public information program. As you know this health information service emanating from the headquarters office of the Indiana State Medical Association is now confined to people in 7 or 8 counties, including Marion and surrounding counties. The service should be extended to the rest of the state’s population and during the next year we will explore and perhaps be in a position to see that this program becomes available to the far corners of Indiana. It has been eminently successful with the beneficial public relations aspects of this program apparent from its use and acclaim.

The Public Information Commission has discussed developing a speakers’ bureau to provide programs for local organizations such as Kiwanians, Rotary Clubs, and other such lay groups made up of local businessmen. Their subjects would deal with the philosophies and policies of organized medicine on socioeconomic issues. The Board of Trustees has authorized the Commission to pursue this concept further. The Public Information Commission feels that it has been demonstrated more than once by other organizations and corporations that such a plan is effective in communicating an organization’s attitudes.

In addition, we feel that it is important that during this next year standards for a statewide emergency medical service system be incorporated in Indiana. Over the years since the National Highway Safety Act of 1966, the Governor’s Advisory Committee on Emergency Medical Services has been developing



guidelines for Indiana and has been constantly rebuffed by the efforts of two groups who are related to emergency medical services in the transport-of-patient phase of a total program.

Recently seven of the professional medical associations of Indiana adopted standards and deadlines for implementing a total EMS program and have presented them to the Governor of Indiana who has looked favorably upon the concepts. Most assuredly, we must proceed as rapidly as possible in instituting the standards.

The American Medical Association, in competition with a number of other proposals on the national level, has developed the Medcredit program for handling the costs of medical care for patients and families to and through catastrophic illnesses. The AMA's concept seems to be attracting vigorous support in the Congress. The plan does not relinquish the entire operation of a national health insurance plan to the federal government. It appears by far to be the best plan for payment for health care, without establishing delivery systems as the others seem to do.

Our legislative activity could continue at its current pace. We feel that we had an effective year in the state legislature. We will make efforts to see that there is better communication between our county societies and the State Medical Association as to progress on bills. We will urge, at every opportunity, individual physician participation through personal contacts with our state's general assemblers.

The malpractice insurance program which is being investigated by the Commission on Medical Economics and Insurance has the possibility of bringing further additional revenues into the Indiana State Medical Association. Involved is the organization by ISMA of a for-profit corporation. Such programs can also benefit the membership by curtailing the need for dues increases as the organization and its activities continue to expand.

Much progress has been made in the accreditation program of hospitals and institutions conducting continuing medical programs for physicians. The accreditation system has been instituted by the Commission on Medical Education and Licensure cooperatively with the American Medical Association which is now depending upon states to qualify these programs for their Physicians' Recognition Award in continuing medical education. This endeavor is worthwhile,

especially since on the horizon there seems to be a growing trend through legislation to require continuing education for many professional groups. We feel that in this voluntary way we will be substantially solving the problem and offsetting a possibility of legislation.

Building expansion has been before the Board of Trustees who are considering aspects of either increasing space in the present location or moving to another, more desirable site. With the activities of the committees, commissions and other groups related to the Indiana State Medical Association utilizing the facilities of the ISMA, it is apparent that we are going to have to acquire more parking space, more personnel, and more office equipment to meet the demands of these groups.

I want to, as a last item, put emphasis on the necessity for committee members and commission members to attend meetings. We are faced with the situation where many accept responsibility on committees and never attend one meeting during the year. Frankly we need the input of physicians in programs and plans which are under consideration by these committees. It is essentially wrong that five men of a 15-member committee should make decisions. I urge the assistance of members of the House of Delegates and members of the Board of Trustees in stimulating closer cooperation in these areas for the forthcoming year.

In my opening statement I said that I want to maintain the status quo. You can see that even with the effort to maintain the status quo, we observe with pride that progress is being made in a number of areas by the Association, but this progress is being made at our own pace and with thoughtful consideration of many dedicated members within the framework of organized medicine. This to me is the way it should be and shall be my plan of leadership for the forthcoming year.

### **Report of Mrs. Willis W. Stogsdill, President of the Woman's Auxiliary to the Indiana State Medical Association**

(Report given by Mrs. Edsel Reed, First Vice President, Woman's Auxiliary)

#### **HOUSE ACTION: Ordered filed.**

It is a great disappointment to me to be unable to give this report in person, but the conflict of an extremely important national meeting with our state

meeting prevented my being present for the opening of the 124th Annual House of Delegates of the ISMA.

Last year, Mrs. Philip Smith, Auxiliary president, urged the ISMA to consider combining their contributions to AMAERF with those of the Auxiliary and I am happy to tell you this was accomplished. We are grateful and proud to tell you there was a 19% increase over last year's figures. The total this year was \$25,232, of which the Auxiliary raised \$21,446. This fund to support grants to medical schools and guarantee student loans is still one of the major and most successful projects of the Woman's Auxiliary to the AMA. The first national chairman, Mrs. Frank Gastineau, who was also an Indiana state president and a national Auxiliary president, was one of its greatest promoters. In the area of scholarship, Indiana Auxiliary members have raised over \$10,000 to be given in many para-medical careers. In addition, health career days have been held in many cities and a health careers conference in Evansville was sponsored by that group. Other conferences in which auxiliaries took part together with Indiana Health Careers, Inc., were held at Purdue and Butler Universities, with some in the planning stages for this year in Allen and Lake counties. Legislation has been a very vital and important part of our Activities and a Legislative Day was held in Indianapolis during the legislative session in which *your* wives took *your* legislators to lunch at the Columbia Club, just to get acquainted. In addition, Indiana was well represented through letters from auxiliary members to their representatives in Washington, D.C., when the AMA asked for help to swell the vote against S.14, Kennedy's HMO Bill. The other ongoing programs of the national auxiliary continue in our state in the areas of Volunteer Nursing Home Visitation, health education in the schools and health services in the community, plus safety, international health and many facets of *all* these programs. WASAMA, the Woman's Auxiliary to the Student Medical Association, has had active support from us both morally and financially.

In January, Dr. Gosman appointed an auxiliary member to each ISMA Commission, in order to obtain the desired input from the Woman's Auxiliary and have a greater coordination of effort between the Auxiliary and the Commissions. We feel this has been a very successful idea and Dr. Dukes has invited us to continue in this capacity again this year. Also, last year, through the sug-



gestion of Dr. Norman Booher, auxiliary members were appointed to serve on the various Boards of the voluntary health agencies which are approved by the ISMA. This, too, will continue under a slightly changed plan.

By planning a much-expanded program for the ISMA Convention this year, we hope we have helped to bring more physicians to the meetings by planning an appealing and worthwhile meeting for doctors' wives. Indiana Auxiliary membership has increased to 2603 members this year. In this number are 67 Members-at-Large. Now that we have the ball rolling again, we hope to increase our membership by an even greater percentage. Indiana Auxiliary is well represented at state and national meetings following the lead of the Indiana State Medical Association in being involved in the future of medicine. It has been my pleasure to work with Dr. James Gosman, your president, and I look forward to my association with Dr. Joe Dukes, your president-elect. I would also like to thank all of *you* for the opportunity to serve as president of a group made possible only because of the physician's existence. Each year you have encouraged *us* to help *you* more in promoting the aims and best interests of medicine in Indiana and we sincerely hope it will continue to an even greater degree in years to come.

**Report of the Indiana Chapter,  
Student American  
Medical Association**

No formal report was given. Schuyler K. Geller, President of the Indiana Chapter of SAMA, reported they were in the process of reorganization and this coming year SAMA would be an active part of organized medicine.

**Report of Chairman of  
Blue Shield  
Board of Directors**  
(Report given by Dr. John Paris,  
Vice-Chairman)

**HOUSE ACTION: Ordered filed.**

**Presentation of Awards**

Volunteer Physicians for Viet Nam—  
Marion E. Ayers, M.D., Indianapolis  
Physician's Community Service Award  
—Everett Bickers, M.D., Floyds Knobs

Scientific Exhibit Awards  
First Place—Austin L. Gardner, M.D.,  
Edward C. Wheeler, M.D., and  
Daniel R. Elliott, M.D., Indianapolis  
Second Place—John M. Tew, Jr., M.D.,  
and Frank H. Mayfield, M.D.,  
Cincinnati  
Third Place—John M. Tew, Jr., M.D.,  
and Sabino Baluyot, M.D., Cincinnati

Award for Andrew C. Offutt, M.D.,  
Indianapolis, for his outstanding contribution to and his participation in activities of organized medicine and on behalf of his support and outstanding services toward quality medical care.

Dr. Heartsill Wilson, Denver, addressed the House.

**Reports of Officers**

**Executive Secretary**

**House Action: Ordered filed. Continuing disparity between expenditures and receipts of the Annual Convention referred to Future Planning Committee for study and solution.**

The following is a resume of the action taken by the 1972 House of Delegates and disposition of those matters.

Items from the printed report of the President.

Item #2. Concerning the restudy of the structure of commissions and committees of the Association. This matter is still under study.

Item #3. Suggestion that the immediate past-president become a member of the Executive Committee and of the Board of Trustees was referred to the Committee on Constitution and Bylaws which will report on this at this session.

Item #4. Concerning election of officers and the timing thereof has been referred to the Commission on Constitution and Bylaws.

Item #7. Concerning budgeting for public relations. This has been referred to the Board of Trustees and the Commission on Public Information. Public Information has reported on this item at this session of the House.

Item #8. Concerning further service programs to the members of the Association

has been referred to the Commission on Medical Economics and Insurance.

Item #9. Concerning membership on reference committees. This matter has been referred to the Commission on Constitution and Bylaws.

Item #10. Concerning computerization of many programs in the state headquarters and investigation of use of computers has not been investigated any further at this time.

Resolution 72-19A. This resolution adopted by the 1972 House of Delegates in lieu of resolution 71-3 and 72-19 were considered together by the Board and reported at the 1972 session of the House. Since that time, it has been referred to the Committee on Finance of the Board of Trustees.

*Supplemental report of the President-Elect*, in which he made a recommendation that interns and residents have a separate section and be permitted to send a voting delegate to the House of Delegates. This has been referred to the Commission on Constitution and Bylaws which reported both last year and will report again this year.

*Report of the Commission on Governmental Medical Services* concerning the establishment of a review committee to handle review of third-party claims on fees was referred to the Board of Trustees.

*Commission on Public Health* report. The house recommended that the Commission in its next report include a section on drugs, all drugs and not just marijuana. Also that this Commission clarify its position on smallpox vaccination in its next report.

It is also recommended that the Commission do a statewide survey on resolution 71-5, a statewide moratorium on amphetamine drugs.

These recommendations were referred back to the Commission on Public Health which will report on them at this session of the House.

*Report of the Commission on Medical Economics and Insurance.*

The report was adopted by the House with specific recommendations as follows:

Item #1. The items dealing with professional review and/or fee review committees and the portion dealing with Blue Shield are referred to the Board of Trustees and were so referred.



Item #2. Recommendation dealing with the establishment of a professional review and/or fee review committee not be adopted but be made available to the Board of Trustees for their deliberation. This has been referred to the Board.

Item #3. Recommended that the Commission make available more than one type of a contract form for use by physicians and their patients to establish the fees to be charged to the patient. The Committee has made such recommendation and report for this session.

*The Joint Report from the Commission on Medical Economics and Insurance and the Future Planning Committee.*

Dealing with the recommendation that the Board of Trustees be directed to establish a mechanism for a statewide corporation to provide for professional review was referred to the Board of Trustees.

*Report of the Commission on Medical Education and Licensure.*

The Committee recommended the establishment of a special membership category known as "Distinguished Members." This has been referred to the Commission on Constitution and Bylaws which will report upon that at this session.

The Commission's recommendation for a model medical practice act was referred back to the Commission for further study and for a legal draft to be prepared and presented to the 1973 session of the House of Delegates. The Committee will make a report on this at this session.

*Report of the Commission on Special Activities.*

The Commission report contained a resolution dealing with the subject that the Indiana State Medical Association endorse the formation of group medical practices in the state of Indiana, etc.

This report was referred to the Board of Trustees.

*Proper Certification of Delegates.*

The Committee on Rules and Order of Business brought to the attention of the House that some of the credentials of the delegates are not properly signed by secretaries of the county medical societies prior to the annual convention and in accordance with Chapter 4, Section 2 of the Constitution. This was referred to the

Board of Trustees which has issued the following ruling, "For seating of delegates at the 1973 and other sessions of this House credentials cards will be forwarded to the secretary of each component county medical society who is supposed to put thereon the name of the delegate and his alternate and properly sign this credential card which must be presented to the credentials committee of the House before being seated as a delegate."

*Report of the Special Reference Committee.*

The Special Reference Committee listed 13 items, all of which have been referred to the Future Planning Committee.

Recommendation #2 that the Special Reference Committee be held annually and this was referred to the Board of Trustees who feel that this should be on a biennial basis rather than an annual basis.

Recommendation #3 concerning circularization of county societies on pertinent material so that they may too consider implementation. These have been sent to the county medical societies.

*Resolutions.*

72-1 Dealing with the Indiana Medical Historical Foundation, was referred to the Board of Trustees and the President was authorized to appoint a special committee to work with Dr. Bonsett and his group. In addition, the Board of Trustees and the Board of Directors of the Medical Education Foundation of Indiana appropriated \$10,000 from funds to assist Dr. Bonsett in his efforts.

72-2 Was referred to the Commission on Legislation.

72-3 Substituting TB skin tests in lieu of chest x-rays, was referred to the Commission on Legislation.

72-4 Fiscal note required on resolutions calling for expenditure of money, has been referred to the Commission on Constitution and Bylaws.

72-5 Creating SAMA representation to the House of Delegates. This has been referred to the Commission on Constitution and Bylaws.

72-7 Medical Department in the Board of Corrections. This was referred to the Commission on Legislation. It also was a part of the Governor's program and it became a law.

72-9 Changes name of the section on general practice to section on family practice. This change was made in the

Bylaws of the Association.

72-10 Utilization of peer review mechanisms. This resolution has been followed and the matter has been referred back to the county medical societies and doctors have been advised of their right to enter into a prior agreement with patients regarding the fee for services to be rendered.

72-11 Cost of hospital care. This was on the agenda for the joint meeting of the Executive Committees of the Hospital Association and the Indiana State Medical Association, but through conflict of dates, the meeting has not yet been held.

72-14 Was referred to the Commission on Public Health and they are reporting their findings back to the House at this session.

72-15 Medical liability legislation. This was referred to the Commission on Legislation and a bill was drafted and introduced in the 1973 session of the legislature but failed to pass.

72-16 Nomination of ISMA officers and AMA delegates. This was adopted by the House and will become effective and operative at the 1973 session of the House of Delegates where nominating speeches will be limited to five minutes, etc.

72-19A Calling for notification of the congressional delegation from Indiana to continue supporting the fee for service and traditional doctor-patient relationship and state licensure of medical practitioners was discussed with the congressional delegation.

The other resolve, that \$3.00 per member be, through an increase in dues, set aside to provide adequate legal counsel for class action suits, was referred to the Board of Trustees Finance Committee.

72-20 Constitutional amendment creating the office of Speaker and Vice-Speaker of the House was referred to the Commission on Constitution and Bylaws which is reporting at this session.

*Membership.*

Membership in the Indiana State Medical Association has shown the largest growth the first six months of 1973 of any year during the past ten years.

I have prepared an analysis of membership trends over the past ten years and you will notice that, as of July 31, 1973, we are showing a gain of



99 new members for the year. The highest previous gain was in 1969 with an increase of 50 members.

The chart also indicates the number of AMA members as of 1973, and you will notice here that we have gained 113 AMA members over the same period last year. As of July 31, we have lost 333, but this is 14 fewer than at the same period last year. President Gosman at the beginning of this year appointed a membership committee with Dr. Peter R. Petrich, immediate past-president, as chairman.

This committee is actively working and trying to interest non-member physicians in the ISMA and AMA for joining or rejoining, whichever the case might be. We hope that this effort will be a successful one showing a good increase in membership at the end of the current year.

Again, I would like to suggest that those counties that have interns and residents in their midst make an effort to provide membership for them in the county medical society as well as the State Medical Association. Under the present Constitution and Bylaws of the Indiana State Medical Association and the American Medical Association, interns and residents are now being given the same active membership as others at a reduced membership fee—namely, \$15.00 for ISMA and \$20.00 for the AMA.

ANALYSIS OF MEMBERSHIP  
TREND OVER PAST 10 YEARS

Year					ISMA Members Non-AMA Members
	ISMA 7/31	Gain Loss	AMA 7/31	Gain Loss	
1962	4307	+ 9	4184	+ 6	123
1963	4330	+23	4222	+38	108
1964	4331	+ 1	4225	+ 3	106
1965	4356	+25	4255	+30	101
1966	4367	-11	4254	- 1	113
1967	4356	-11	4180	-26	176
1968	4400	+44	4246	+66	154
1969	4450	+50	4301	+55	149
1970	4457	+ 7	4291	-10	166
1971	4489	+32	4236	-55	253
1972	4526	+37	4179	-57	347
1973	4625	+99	4292	+113	333

ANNUAL MEETING:

For your information, I am submitting a list of companies which have exhibited with the Association for the past several years, but who have notified the Headquarters that they will not exhibit this year. They are:

Burroughs Wellcome, Co., Dome Laboratories, Eaton Laboratories, Lederle Laboratories, Ortho Pharmaceuticals, Parke-Davis & Company, Roche Laboratories, Searle Laboratories, Smith Kline & French Laboratories, and USV Pharmaceutical Corporation.

As of this report, 28 spaces in the exhibit hall have been sold to 25 companies for a total income of \$7,900.

Under the circumstances, the growing lack of interest in exhibiting is creating each year the need for increased funds from the treasury of the Association to offset the costs of the Convention.

CHAMPUS:

From June 1972 through June 30, 1973, the Champus department paid 18,499 claims. These claims included physicians claims, drugs and outpatient hospital. Total outlay of funds was \$1,459,762.07.

With the elimination of obstetrical and gynecological services at Fort Benjamin Harrison and Grissom Air Force Base, all active duty dependents requiring this care will now come under the CHAMPUS program and claims will be processed through ISMA headquarters, which, of course, promises a greater claim load during the forthcoming year.

FIELD SERVICE:

With the employment of a legislative assistant, the field staff of the Association was able to give more time to other than legislative affairs of the ISMA on a continuing basis. They, however, continue to assist in legislation by keeping physicians informed on current status of legislation and working in conjunction with the legislative assistant in gathering data and information from the field for use by the Commission on Legislation.

In addition, the field staff has assisted with gathering survey material at the specific request of Commissions, and are currently making contact with county societies and physicians to ascertain physician contact with members of the communications field throughout Indiana, so that more effective reporting on ISMA news releases and information emanating from the Headquarters Office can be developed.

Current plans for the field staff call for more active staff help in planning District meetings, membership promotion, and continued liaison with county societies and individual physicians.

LEGISLATION:

Through a full time legislative assistant, the Association has benefitted from a much closer liaison, year round, with members of the General Assembly, legislative study groups and the ISMA membership at large.

This department will be keeping county medical societies up to date on the status of legislation through periodic reports and has also initiated a new bulletin on medical political activity through the IMPAC News. This new department, we believe, will give the ISMA a more effective role in its lobbying activities during the actual session.

In addition to legislative activity at the local and state level, this department will keep itself apprised of legislative actions at the Federal level and maintain close contact with the AMA headquarters and the AMA Washington office.

The forthcoming year will see greater concentration on educating the membership to the value of membership in IMPAC and AMPAC and an effort to inform the membership of the effect and results of their political action dollars.

PUBLIC RELATIONS:

Public relations is involved in all of the activities of the Association and is not necessarily confined to the printed word in newspapers or the spoken pictorial presentations on radio and television.

The Commission on Public Information of the ISMA is continuously working toward programs which can present the true picture of organized medicine and the practicing physician. As everyone in the profession knows, there has been much irresponsible reporting of facts and figures on health care costs and the current medical care delivery system. One major example of this was the national program aired by NBC entitled "What Price Health?"

In an effort to counteract such misleading and grossly inaccurate reporting, the ISMA Public Information Commission is working toward the development of a professional Speakers Bureau which can represent, on a pre-scheduled basis, the ideas and philosophies of the medical profession and present true facts and



statistics of the socioeconomic scene to lay clubs and organizations throughout the state.

The byproduct of such programming with the advance news stories on appearances, news coverage at the site of the speaker's engagement and followup stories in public print, as well as the word-of-mouth communication of the audience with those not in the audience, constitutes the ingredients of an *action program* with resultant good public relations for the profession. It is our hope that the Association will see fit to endorse the program and create funds for its development.

The Association continued to act as a clearing house for information to the Hoosier public on an untold variety of subjects from questions on abortion clinics to providing information to a sixth grader for a report on the damaging effects of drug usage. The variety of requests is limitless.

#### USE OF BUILDING:

Use of the building is increasing annually, with meetings being held throughout the week and on Sundays by ISMA Commissions, Committees, Auxiliary Committees and committees of health related groups such as medical specialty groups, Regional Medical Program, voluntary health associations and medical student groups.

A portion of the staff is on a six to six-and-one-half-day work schedule a greater portion of each year due to the increased programming by the Board and the Commissions.

Currently the building is at capacity usage with the current staff and space for necessary mechanical equipment to conduct the affairs of the Association.

In conjunction with the constant usage of facilities by the many groups and committees, is the limited capacity of the parking area, and the lack of adequate storage space.

Study is now being undertaken by the Board to determine courses for possible expansion in view of future needs which can be foreseen from the need for more staff to act as liaison with Comprehensive Health Planning, manage the new Continuing Medical Education Accreditation Program, perhaps administrate the forthcoming PSRO and other government programs which may appear and conduct the administration of other developing programs initiated by Commissions and the Board of Trustees.

#### OTHER PROGRAMS:

In addition, following are programs being planned or now in effect. Some of them will have a direct effect on the additional utilization of Headquarters space and additional manpower needs for the ISMA.

The American Medical Association will no longer credit institutional and organizational programs designed for continuing medical education in states and local communities. They are going to confine their efforts to national organizations and groups. As a result of this, the Commission on Medical Education and Licensure of the Indiana State Medical Association has proceeded with a plan for accrediting institutions and organizations in Indiana and has received from the American Medical Association provisional approval for one year.

Essentially, an organizational institution wanting to receive accreditation will complete a rather detailed questionnaire on its programs and then will be visited by a team of physicians to make an on-site evaluation. Their accreditation will be determined on the basis of five different classifications ranging from a full accreditation with the last classification as non-accredited.

This program is a voluntary program for institutions and physicians and will in no way affect a physician's membership status with the Indiana State Medical Association. As you know, two or three states in the country have instituted continuing medical education as a prerequisite to membership in their respective state medical organizations, or for license renewal.

Physicians completing courses which are accredited by the Indiana State Medical Association, 150 hours over a three-year period, will be eligible for the AMA's Physician Recognition Award and will also have their particular award sealed with a special ISMA accreditation emblem and will also receive a special membership card identifying them as a Distinguished Member of the organization.

#### MALPRACTICE INSURANCE:

The Commission on Medical Economics and Insurance is currently working on a plan at the request of the Board of Trustees of the ISMA which has the potential of establishing for the state of Indiana an ISMA for-profit corporation which initially would deal with managing

malpractice insurance for members of the Association.

Such a plan has been successful in Florida with the Florida State Medical Association participating. Involved would be the ISMA owning 49% of the stock in the company with the broker owning 51% of the stock. It is anticipated that under the plan the State Medical Association could earn from \$75,000 to \$100,000 a year from the program which, in effect, could assist in the budget requirements of the ISMA. With the ISMA managing a malpractice insurance program for the doctors, premiums could be lower, and many of the malpractice cases could be arbitrated outside of courts, which would block much of the unnecessary litigation. The Commission and the Board of Trustees is enthusiastic about the idea.

#### BOOKLETS:

Since October the ISMA has produced two leaflets—one on Medicare which explains to the patient some of the true facts about the Medicare program. Many Medicare patients take for granted that all their bills will be paid under the program. The leaflet is an effort to clarify this for the patient so that he will understand the true facts about the Medicare program. In addition, the ISMA also wrote and produced a leaflet on Medicaid which was designed to help the Medicaid patient understand the rules and regulations of his medical care. These leaflets have been widely ordered. We find that the physicians using them in their offices are highly appreciative.

In addition to these leaflets, the Commission on Public Information is currently planning the development of a leaflet which would explain to the patient that health insurance plans dictate the principles of the policies within the plans and do not necessarily mean that when a patient purchases an insurance policy that he is totally covered. It will attempt to clarify for the patient the fact that, even with insurance, coverage in certain areas and the costs are not total.

The commission developed and published in The Roster issue of the *ISMA Journal*, a booklet on how to avoid malpractice and legal problems. It is an excellent guide and it is hoped that members will utilize it as a desk reference.

#### TEL-MED:

The Association also installed Tel-Med telephone equipment in the headquarters office. There are 10 telephone lines



which come into the headquarters office on which any person interested in any of the 100 subjects can call in and hear a brief three- to five-minute medically approved tape on the subject requested. Currently involved is the Marion County area and about 9 or 10 counties in the immediate surrounding toll-free area of Indianapolis. The program has met with outstanding success.

From March 22, 1973, the date for inception of the program, to June 30, the Tel-Med exchange received 38,947 calls. 5,170 of these calls were recorded on weekends, during which time the exchange is not in operation.

The program has necessitated the hiring of an operator to handle calls.

**RETREAT:**

In mid-March, the Commission on Medical Education and Licensure conducted the third annual Retreat with medical students and I.U. Faculty in Brown County in a two-day session. The purpose of this meeting, as in other meetings, is to, in an informal atmosphere, discuss with the students and the faculty medical education in general. The turn-out for the meeting was excellent and the outcome of this meeting was that students showed interest in

getting more information on the administrative side of medical practice. The impact of this meeting is that the medical school listens, the medical school participates, and many of the recommendations emanating from this meeting eventually filter into the curriculum and programs for the medical students at I.U. Much interest was expressed this year in the problems of communities wanting physicians. Such a program, too, alerts the student to organized medicine and its problems and objectives which is an indirect benefit to ISMA.

**INSURANCE PROGRAMS OF THE ASSOCIATION:**

The disability income program and the life insurance program continue to grow. More and more physicians are participating in these programs, which of course, are direct benefits.

**EMERGENCY MEDICAL SERVICES:**

With the co-operation of the Indiana State Nurses Association, the Indiana Hospital Association, Regional Medical Program, the State Board of Health, and the Governor's Office, the Commission on Emergency Medical Services held a

one-day conference on Emergency Medical Services. Attending were 650 people from throughout Indiana, representing all groups involved in emergency services throughout Indiana.

Emphasis in the program was to coordinate the efforts of these various groups in instituting an effective plan for Indiana through legislation. Hopefully, the Conference will produce positive steps by the legislature with resultant benefit to the profession, hospitals and the Indiana public.

**OTHER SERVICE OF THE ASSOCIATION:**

The last three trips which have been endorsed by the ISMA, which are international tours, have been completely filled by Indiana physicians and their wives and families marking them as a desired service by the membership.

Your secretary has deliberately mentioned these programs which may well be enumerated in other reports to the House. The membership should be aware of the fact that they are the result of long hours of deliberation and planning by the Commissions and Committees of the Association and continuous follow-up by the ISMA staff. As the pro-

**INDIANA STATE MEDICAL ASSOCIATION  
Statement of Financial Condition at June 30, 1973**

<b>ASSETS</b>	<b>General &amp; Journal</b>	<b>Building Fund</b>	<b>Medical Defense</b>	<b>Student Loan</b>	<b>TOTAL ALL FUNDS</b>
Cash in banks-operating .....	23,534	2,255	805	—	26,594
Cash in banks-interest bearing .....	20,000	6,852	19,086	19,190	65,128
Short term treasury bills .....	288,247	150,150	—	—	438,397
Accounts receivable .....	24,905	357	1,367	—	26,629
Prepaid expenses .....	10,925	1,352	—	—	12,277
Long term investments .....	85,977	—	25,095	20,810	131,882
Property-less reserve for depreciation .....	20,873	403,627	—	—	424,500
Total Assets .....	<u>474,461</u>	<u>564,593</u>	<u>46,353</u>	<u>40,000</u>	<u>1,125,407</u>
<b>LIABILITIES AND FUND BALANCES</b>					
Accounts payable .....	2,162	691	—	—	2,853
Property taxes accrued .....	—	2,390	—	—	2,390
Deferred annual meeting .....	955	—	—	—	955
Dues payable to AMERF .....	20,070	—	—	—	20,070
Non-interest bearing notes .....	—	20,925	—	—	20,925
Advances from AMA .....	9,278	—	—	—	9,278
Deferred dues income .....	210,742	—	—	—	210,742
Total Liabilities .....	<u>243,207</u>	<u>24,006</u>	<u>—</u>	<u>—</u>	<u>267,213</u>
Fund Balances October 1, 1972 .....	206,915	497,414	43,350	40,000	787,679
Excess income nine months .....	24,339	43,173	3,003	—	70,515
Fund Balances at 6/30/73 .....	<u>231,254</u>	<u>540,587</u>	<u>46,353</u>	<u>40,000</u>	<u>858,194</u>
Total Liabilities and Fund Balances .....	<u>474,461</u>	<u>564,593</u>	<u>46,353</u>	<u>40,000</u>	<u>1,125 407</u>



grams increase, so grows the demand for personnel.

I would also observe that the initiation of new programs is developing with more intensity each year. The Association has gone far beyond the stage of philosophizing and offering advice on matters of importance in the medical and health field. The Association, like every other organization, has found it necessary to become actively involved in issues and programming for its own benefit, and in those areas where it rightfully has the responsibility and authority to participate.

This must continue, since, as has been demonstrated during the past decade, if medicine does not remain active and aggressively energetic in its own behalf, third parties will and do assume these responsibilities, and not necessarily in the best interest of the profession.

JAMES A. WAGGENER,  
*Executive Secretary*

## Treasurer

### HOUSE ACTION: Ordered filed.

The audit for the fiscal year ending September 30, 1972, was published in detail in the March 1973 *Journal*. Inasmuch as the current fiscal year ends September 30, 1973, the audit will not be available for presentation to the House at this time.

I have prepared a statement of financial condition of our Association for nine months of the current fiscal year which appears on the previous page. It appears at this time your Association is in good financial position.

HUGH K. THATCHER, JR., M.D.  
*Treasurer*

## Chairman of the Board Report

### HOUSE ACTION: Ordered filed.

The Trustees met immediately following the adjournment of the final session of the 1972 House of Delegates for the purpose of organizing. Dr. Gilbert M. Wilhelmus, Evansville, was elected Chairman; Dr. Vincent Santare, Munster, Dr. Donald Kerr, Bedford, were elected members of the Executive Committee.

I wish to express my gratitude to the members of the Board for electing me Chairman. The experience obtained from this position has been interesting and rewarding, and has given me a much

broader view of the workings of organized medicine in our State Association. I wish to express my appreciation to the members of the Board for the many hours of tedious work. Also, I wish to express my appreciation for the staff at the ISMA building, the field men, the legislative assistant, and Mr. James A. Waggener.

During the past year the Board has met many times and worked very hard. The majority of our meetings were two-day meetings. The meetings were set up as follows: discussion, informative outside speakers, reports of the Commissions, and policy statements. I shall attempt to highlight some of the significant accomplishments. Much of our time has been spent in discussing the involvement of the government in medical care, particularly PSRO.

### NOVEMBER 19, 1972, MEETING

The AMA Delegates reviewed for the Board resolutions and committee reports which would come before the AMA House of Delegates. There was much discussion by the Board and Delegates on the enormous volume of business to be transacted. Donald E. Wood, M.D., AMA Trustee, reported that the American Medical Association projected savings of \$840,000 in its reorganization plan of councils and committees. A discussion was held on the possibilities of who is to fill the position of State Health Commissioner—at this time no successor has been found.

Two representatives from the Health Services and Mental Health Administration, Department of Health, Education, and Welfare, reported to the Board. They wished for Indiana to be one of five states in a test project which would involve the use of uniform reporting forms for physicians from the Medicare and Medicaid programs. Fees for procedures would also be reported on the forms. Following lengthy discussion and questions, the Board voted not to participate in the project.

President Gosman reported that four physicians from the U. S. Public Health Service had been assigned to the staff of the Marion County Neighborhood Clinics. He also stated that the Marion County Medical Society Executive Committee had approved the service in accordance with regulations, and the program requested the approval of the ISMA. The Board approved the plan contingent upon the approval of the Marion County Board of Trustees.

Dr. Vincent Santare reported on the Professional Standards Review Organization. The all-encompassing bill on health care delivery deals with such subject matters as: definition of a qualified organization to form PSRO, authority for hospital admissions, patient and physicians profiles, review of qualifications, use of Hospital Review Committee, certification of in-patient care, grounds for exclusion, and others. This matter was then referred to the Board Committee for study and implementation of governmental medical programs.

It was noted that legislation requiring plaintiffs in malpractice cases to post bond will be introduced in the state legislature on the action of the Board. The plaintiff will be required to deposit a \$500 surety bond. Should the plaintiff lose the case, he will be required to pay the court costs.

### JANUARY 20-21, 1973, MEETING

The Board went on record extending the services of the headquarters offices to the speciality societies. The Board passed a motion unanimously whereby the Women's Auxiliary to ISMA received credit for all AMA-ERF collections in the state. This should place the auxiliary in a better position of competition with other state auxiliaries.

The Board sent letters to all Indiana congressmen informing them of the Federal Drug Administration's action in regard to the new regulations which continually remove drugs from the market.

Dr. Donald Wood, AMA Trustee, reported that the AMA is asking state societies to do nothing about organizing PSROs. At this time there has been no director named in the Department of Health, Education, and Welfare.

The discrimination against physicians under the new Phase III program was discussed at length.

The AMA's Medigredit bill was discussed—helps individuals with catastrophic illnesses. The Board went on record as favoring this bill.

The Board rejected participating in the Quality Assurance Program being planned by the Indiana Hospital Association.

Chairman of the ISMA Commission of Public Information gave a report on the speakers bureau. The Board unanimously was in favor of this program and felt that in time this would be an excellent way for ISMA to tell the true story of medicine.

Indiana University Medical School Department heads, the I.U. Medical School



Alumni, and members of the ISMA Board met with the Dean of the I.U. School of Medicine. The department heads gave a very comprehensive report on the policies and functions of the I.U. Medical School.

Chairman of the ISMA Medical Economics and Insurance gave a report on the coordination of benefits in health insurance policies. The Board moved that the Commission investigate the cost of malpractice insurance policies and continue to study this problem.

The Board moved not to introduce a free standing physician assistant bill.

The Third District Trustee gave a report of his personal survey in his district on PSRO. Seventy-two of his colleagues returned his questionnaire—29 agreed with the AMA House Action on PSRO, 30 opposed.

#### FEBRUARY 11, 1973, MEETING

The Board unanimously voted to give President Gosman the authority to proceed with a class action suit against PSRO law and Phase III regulations. The Board further went on record as opposing the principles of PSRO.

Dr. Alcorn gave a report on the status of the Medical Practice Act.

Wayne Stanton, new director of the State Department of Public Welfare, reported to the Board that his department was compelled by a federal mandate to consider the screening of all young people and children 21 years of age and younger under the Medicaid program. He stated that retaining federal funds for state welfare was at stake. His plan was not to engulf the medical profession in Indiana with the project, but he was desirous of screening as many of these children and young adults as possible through the surveys of parents, teachers, and other individuals.

James Herod, president of Blue Cross, reported to the Board on the health care crisis in the United States. He said that he felt this was the time for Blue Cross-Blue Shield, ISMA, Indiana Hospital Association, and other health care groups to work together in the action program for the betterment of health care for Hoosiers. Mr. Herod (to carry out this action program) listed 12 objectives, which the Board endorsed.

#### APRIL 14-15, 1973, MEETING

The Board had a long and thorough discussion of the Professional Standards Review Organizing Law, and it reiterated its previous action of going on record as opposing the PSRO and to continue to fight the concept.

Dr. William Paynter, the new Indiana State Health Commissioner, stated that the health activity in the federal system is undergoing a major reorganization. The Board was impressed with Dr. Paynter's comments.

David Johnson, executive director of Deaconess Hospital, Evansville, gave a report on the use of computers in the practice of medicine. Also, Mr. Johnson gave a report in which the "Washington Post" cited corruption in hospitals throughout the nation.

Dr. Robert Reid gave a report on Medi-Tech—another computerized system.

Roger Zion, congressman from the Eighth Congressional District, gave a report of the health bills in the present Congress. He was asked about class action suits against any of the laws that have been passed. In his opinion, this type of action should be the last resort.

H.M.O.s received considerable discussion by Board and the Board disapproved this type of organization for delivery of medical care. The Blue Shield representative queried the Board concerning the advisability of their acting as Fiscal Intermediaries for such plans in Indiana, and the Board moved that, when a specific proposal was received by Blue Shield for acting in this capacity with HMO, they return to the ISMA with the request, and that in the meantime the Board go on record as being unalterably opposed to the HMO concept.

Mike McDermott, legislative assistant of ISMA, reported to the Board regarding the 104 bills dealing with subjects related to the medical profession. Forty of these bills failed, while 26 will be signed by the Governor. Fifteen bills were strongly supported by the ISMA, of which 7 will become law, and 8 failed. The Board applauded Mr. McDermott for his work with the Legislature.

The Board gave the "green light" for the chairman of the ISMA Medical Economics & Insurance Commission to continue discussion in regard to the Florida Medical Association Plan for handling malpractice insurance.

A request for contributions to the Eisenhower Memorial Scholarship Fund was rejected by the Board.

The Board was pleased with their Tel-Med Program which was installed earlier this year. They have been receiving (on an average) approximately 800 calls a day.

Dr. Grosz gave a report on the effectiveness of the drug Propranolol in blocking heroin effects. The Board

moved that it assist Dr. Grosz in his work. It was gratifying (at a following meeting) to see the effectiveness of the State Organization action, since by our assistance he was able to gain a grant from the federal government.

Chairman of the ISMA Commission of Emergency Medical Services gave a report on emergency care. The Board approved the Commission's plans.

#### MAY 20, 1973, MEETING

The Board approved the report that the Building Committee should explore the expansion or move of the ISMA building, since the present facilities are overflowing its present capacity.

The at-large members representing ISMA on the Blue Shield Board met with the ISMA Board of Trustees to discuss current plans to expand Blue Shield Board. Everyone thought the discussion was good—ideas and thoughts were received in both directions.

The Board moved that the House of Delegates, in our October meeting, make the decision whether state medicine become involved with PSRO concept.

#### JUNE 17, 1973, MEETING

The AMA delegates and alternate delegates gave a thorough and excellent report on the matters being referred to the Reference Committees at the AMA meetings in New York.

#### JULY 15, 1973, MEETING

This meeting was set aside to discuss PSRO and what presentation we should make before HEW on July 24, 1973. In the discussion it was noted that the Board was on record as favoring the House of Delegates, at our annual convention in October, to decide whether we govern PSRO. In order that all avenues of discussion at our annual convention will be given, the Board voted, at this time, to present a state-wide "umbrella" PSRO in their presentation before HEW.

A discussion on continuing education, in regard to recertification and relicensure, followed. This discussion centered around keeping the Trustees informed on this topic which has been brought to the forefront at the AMA level.

#### IN SUMMARY

The Board planned and participated in many programs that are not mentioned in the preceding report; for instance, the Washington Legislation Visitation, the Student-Faculty-ISMA member meeting at Nashville, our Treasurer's financial report, etc. A more complete report can be obtained in the editions of



GILBERT M. WILHELMUS, M.D.  
Chairman

## First Trustee District

HOUSE ACTION: Ordered filed.



GILBERT M. WILHELMUS,  
M.D.  
Trustee

The annual meeting of the First District Medical Society was held on May 24, 1973, at the Rolling Hills Country Club, Evansville.

The meeting was well attended, with over 170 members and their wives. Mead Johnson was the host for our social hour preceding the dinner. It was noted at the meeting that Mr. O. Miller, physician representative from Mead Johnson, was retiring this year. All the physicians in the First District wished Mr. Miller many years of retirement enjoyment.

Otis Bowen, M.D., the Honorable Governor of the State of Indiana, was our speaker. All the physicians and their wives were pleased to visit and talk with Governor Bowen—he is held in high esteem in our area as well as over the entire state. Dr. James Gosman, ISMA President, was present and gave a comprehensive report on our business at the state and national level. Dr. Gilbert M. Wilhelmus, Chairman of the Board of Trustees of the ISMA, gave a report on the activities occurring at the state level, and especially a report on PSRO. He urged the members to become well informed in regard to the PSRO concept in order to let their representatives know what action to follow at our state convention. Mr. James Waggener, Executive Secretary of ISMA; Mr. Robert Amick, District Representative; and Mr. Mike McDermott, Legislative Assistant of the ISMA—were in attendance. Mr. McDermott gave a summary of the bills introduced into the state legislature—and in particular of the 104 bills which had some bearing on the physicians in our state. Dr. Willard T. Barnhart, First District Representative on the Blue Shield Board of Directors, gave a report on the activities of Blue Shield. He stated that the Administrative consolidation of Blue Cross-Blue Shield has been working very well. He further stated that, should this

arrangement become unworkable in the future, it can be terminated by either party at any time. Mr. Herbert Dixon, vice-president of Professional Relations of Blue Shield, was in the audience and was available to answer any questions regarding Blue Shield matters.

After the meeting the following officers were elected:

William Dye, M.D., President  
Albert Ritz, M.D., Vice-President  
John M. Bender, M.D., Secretary-Treasurer  
Ralph Carlson, M.D., Representative to Indiana Blue Shield  
Bernard Rosenblatt, M.D., Alternate Trustee

Postgraduate medical education is still one of our primary interests in the First District. Dr. Corcoran, head of the I. U. Medical School Extension Program in Evansville, is developing excellent medical facilities for teaching medical students. As a result, there has been an increase in the number of medical students desiring to obtain their medical education in our locale. Since postgraduate education is in the forefront, the number of interns and residents is increasing yearly.

Some of the highlights in the past year which have occurred in the First District (especially in Vanderburgh County) are: 1. Organization and implementation of the Peer Review Committee. 2. The Answering Service Feasibility Study carried out by the Emergency Service and Indigent Care Committee. 3. The organization of the Medical Review Committee. 4. The acquisition of many new physicians. 5. An orientation meeting for newer members to instruct and show them how the AMA, ISMA, and County Medical Society can help them and how they can help these organizations. 6. The creation of the Ad Hoc Committee to investigate a medical guild.

As a member of the Board of Trustees of the Indiana State Medical Association, it is rewarding to see the number of physicians working together helping organized medicine to be the leader in the health care field. Moreover, it is obvious that the great majority of physicians in the state of Indiana do not want third party involvement. The trustee wants to thank the many members of the District for their cooperation and activity in their local medical society and in participating on the commissions and committees of the ISMA.

The District appreciates the efforts of Mr. Robert Amick for his attendance and suggestions throughout the entire

District.

The trustee is grateful for the cooperation and opportunity to serve his fellow physicians in the First District.

GILBERT M. WILHELMUS, M.D.,  
Trustee

## Second Trustee District

HOUSE ACTION: Ordered Filed.



PAUL W. HOLTZMAN,  
M.D.  
Trustee

The Second Medical District met May 17, 1973, at the Fourwinds Inn on Lake Monroe with Dr. Robert Robinson presiding. It was decided that the next meeting would be at Sullivan.

The afternoon session was a two-hour discussion chaired by Dr. Paul Holtzman, on HMO, PSRO, and other current medical events. The meeting was poorly attended.

In the evening, the Honorable Lee Hamilton, Congressman from Indiana, spoke regarding the present and future of American medicine. This meeting was also poorly attended.

During this year, I have made every effort to bring the Indiana State Medical Association to the doctors in this district, and made every effort to acquaint the physicians with the benefits therefrom derived.

There is general apathy, distrust, and misunderstanding regarding the role of the Indiana State Medical Association and its relationship to the practicing physician. There is little interest in what has been or what can be accomplished by the association.

Certainly, in my opinion, something must be done to properly inform and organize men in the district as, at present, they are all floundering in disarray awaiting the inevitable and seemingly reluctant to speak their piece or participate in any concerted action toward preventing government interference in medicine. Hindsight abounds—foresight is ignored.

We have a continuing responsibility and opportunity to educate regarding American medicine but we **must** start with the doctor.

PAUL W. HOLTZMAN, M.D.  
Trustee



## Third Trustee District

### HOUSE ACTION: Ordered Filed.



ELI GOODMAN, M.D.  
Trustee

At the 1972 meeting of the Third District held in May at New Albany, it was agreed to hold the 1973 meeting in September.

Accordingly, the 1973 meeting is scheduled for Wednesday September 26, with the meeting to begin at 4:00 p.m. at the Marriott Inn at Clarksville, and with golf available at the Valley View Golf Course at New Albany.

The after-dinner speaker will be Dr. Richard C. Bates, the Lansing, Mich., internist who is noted as a humorist. State officers will be present to discuss PSRO pending legislation and other items of current interest to the medical profession.

Claude J. Meyer, M.D., will preside as district chairman, assisted by Robert McKechnie, M.D., district secretary. A district trustee is scheduled to be elected during the business meeting.

During the past fiscal year there were some intramural problems in Lawrence and Orange counties, all of which were probably based on faulty communications. State Association President James Gosman has visited both counties and used his good offices to bring about satisfactory resolutions. I am continuing, in my position as Trustee, to try to amicably adjudicate a remaining problem involving ethical intra-relationship.

In another situation, I have made an ongoing effort to assist one physician who had begun to be criticized for an apparent decrease in his efficiency which, I am satisfied, if it existed, was brought about by many hours of overwork in an area very short of physicians.

Probably the most serious single issue to confront the district membership this year has been the national problem of decision making brought about by the passage of the law providing for Professional Standards Review Organization. (PSRO).

I personally consider that the impact of PSRO, when it has been fully implemented, will entirely change the nature of the medical care of the American people (unfavorably) and, of course, the effectiveness and life-position of each and every physician along with it.

Therefore, I polled the membership of the Third District by certified mail (at my own expense). About one fifth (1/5) of the members replied. About two out of three replies were opposed to PSRO. As a result, I have considered myself to be mandated to oppose PSRO at all levels. This I have done in visits to component county societies, and by motion and vote in all meetings of the Board of Trustees.

I was also the only physician from the state of Indiana to give public testimony in opposition to PSRO before the Reference Committee at the June 1973 meeting of the American Medical Association in New York.

At the annual meeting of the Indiana State Medical Association this October, a resolution will be presented from Clark County, which is one of my constituent counties and is my home county, that will oppose PSRO.

I urge all delegates from the Third District (and indeed all districts of ISMA) to carefully study all the issues involved in PSRO.

Decisions made by the House of Delegates this October, will probably be the most important that organized medicine have ever been called on to consider.

ELI GOODMAN, M.D.  
Trustee

## Fourth Trustee District

### HOUSE ACTION: Ordered Filed.



HOWARD JACKSON,  
M.D.  
Trustee

The 1973 meeting of the Fourth Medical District was held in Columbus, on May 9, 1973. Presiding was Dr. Kenneth Schneider. The meeting was well attended. Members of the District were particularly pleased that the President was present for the meeting. Many members of the ISMA staff were present, for which we are appreciative.

Elections were held, and Dr. Jack Shields was elected president, Dr. William Warn was elected vice president, and Dr. John Ripley was elected secretary-treasurer. Dr. William Blaisdell was re-elected alternate trustee. Mr. Tommy Mont, head football coach and athletic director at DePauw University, was the speaker at the evening meeting. His humorous talk was enjoyed by all. Next

year's meeting will be hosted by the Jackson-Jennings County Medical Society in Seymour. The date has not been determined.

The traveling golf trophy was retired by Dr. Richard O'Bryan. There was a tie for second low gross between Drs. Shaffer Berkshire, Donald Moore, and Kenneth Schneider.

As your Trustee, I visited several of the County Society meetings. The discussions and exchange of ideas at these meetings were a great help to me in representing you at the Board of Trustees meetings. I would like to be able to visit each County Medical Society meeting at least once each year. I think it is vitally important for the Trustee to be cognizant of the thinking of the physicians in his district.

HOWARD JACKSON, M.D.,  
Trustee

## Fifth Trustee District

### HOUSE ACTION: Ordered Filed.



CLEON M.  
SCHAUWECKER, M.D.  
Trustee

The annual meeting of the Fifth District Medical Society was held on May 23, 1973, at the Windy Hills Country Club at Greencastle. The business meeting was called to order at 4:00 p.m. by James C. Lett, M.D. Approximately 40 members were present.

The district was pleased to have Gilbert M. Wilhelmus, M.D., chairman of the Board of Trustees, as a guest. He spoke on ways of strengthening the district societies and also on the present status of PSRO. This projected a lively discussion and it was the unanimous opinion of all present that PSRO is a very poorly written piece of legislation and probably not workable; however, it was pointed out that the only way it might possibly work would be for physicians to be in charge. A resolution was passed that the Fifth District go on record as being in opposition to PSRO.

A movie produced by the AMA was then shown concerning some of the problems confronting the medical profession and for the necessity of all doctors to work together in an effort at finding solutions.

Mr. Mike McDermott then gave a summary of the legislation passed dur-



ing the last session of the legislature. Mr. Herb Dixon of Blue Shield then spoke and informed the group that Blue Shield would not, under any circumstances, act as a PSRO agent or become involved.

The election of new officers was then held and the following were elected:

Alternate Trustee—William G. Bannon, M.D. (Terre Haute)

Blue Shield Representative—Fred Dierdorf, M.D. (Terre Haute)

President, Fifth District (1973-1974)—J. Franklin Swaim (Rockville)

Secretary-Treasurer, Fifth District (1973-1974): Antolin M. Montecillo, M.D. (Clinton)

The final business item was the proposal to obtain a secretary for the entire Fifth District. This proposal will be studied by a committee composed of the presidents of each county society in the district, plus the newly elected president, Franklin Swaim. They shall report to our respective county societies no later than September 1973.

Following the business meeting, dinner was served to approximately 75 members. The featured speaker of the evening was Charles C. Hite who spoke on "Humor—Not Aspirin." The talk was very well received.

It was the opinion of those present that this was the best planned Fifth District meeting in many years. A great debt is owed not only to the present officers but also to the staff of the State Medical Association for its assistance.

CLEON M. SCHAUWECKER, M.D.  
*Trustee*

## Sixth Trustee District

HOUSE ACTION: Ordered Filed.



PAUL M. INLOW, M.D.,  
*Trustee*

I wish to take this opportunity to acknowledge the support that Dr. Glen Ward Lee, alternate trustee from the Sixth District, has given me by his tremendous attendance record at the trustee meetings this past year.

This has been an exciting year at the state level with Dr. James Gosman at the helm. We have seen the launching of Tel-Med in Marion County and the beginning of a speakers' bureau to tell the physicians' story, which was initiated by the Commission on Public Informa-

tion. These are both great public relations ideas.

The Sixth District Meeting was held at the Durbin Hotel at Rushville May 2, 1973. Dr. James Gosman, president of the Indiana State Medical Association, addressed the group. He explained the need to form a Professional Services Review Organization, at least on paper, at the state level. A show of hands indicated an overwhelming majority were in favor of proceeding along these lines.

The new officers of the Sixth District are: President—James H. Tower, Jr., M.D. of Shelbyville, Vice-President—Davis W. Ellis, Jr., M.D. of Rushville and Secretary-Treasurer—Arlington M. Hudson, M.D. of Connersville.

The after-dinner speaker, Rev. Phillip Philbrook, a Baptist Minister from Ft. Wayne, was introduced by Past-President John Moenning. Rev. Philbrook's speech was entitled "The Three Bones." The presentation was interspersed with humorous stories and gave criteria for a successful life. The Funny bone symbolizes a need for a sense of humor, the Wish bone a desire for life goals and the Back bone the perseverance to accomplish these goals.

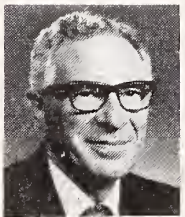
P. M. INLOW, M.D.,  
*Trustee*

## Seventh Trustee District

HOUSE ACTION: Ordered Filed.



JOHN O. BUTLER, M.D.,  
*Trustee*



JOSEPH F. FERRARA, M.D.  
*Trustee*

Dr. Ray D. Miller of Martinsville was elected president-elect of the Seventh District Medical Society at the organization's annual meeting held June 20, 1973, at the Speedway Motel in Indianapolis. He will succeed Dr. Eric D. Clark, of Plainfield.

Dr. Malcolm O. Scamahorn of Pittsboro was reelected Secretary-Treasurer.

The meeting was held following an afternoon of golf and a demonstration of handwriting analysis for the members' ladies.

Dr. Donald E. Stephens of Indianapolis, president, called the meeting to order after members had viewed a motion picture on American Medical Association membership and activities. He then introduced Michael H. McDermott, legislative assistant, Indiana State Medical Association, who reviewed actions of the 1973 Indiana General Assembly pertaining to medicine.

Dr. James H. Gosman of Indianapolis, president of the state association, then discussed that body's actions and positions in regard to the American Hospital Association's Quality Control Program, Professional Standards Review Organizations, malpractice insurance and state headquarters space limitations.

Dr. Gosman moved, seconded by Dr. Ted L. Grisell, of Indianapolis, that the district society oppose any hospital direction which would establish limitations of medical practice and that the society insist that hospital privileges be kept under the control of medical staffs. The motion was carried.

Following an address by the Rev. Phillip C. Philbrook of Fort Wayne, the meeting was adjourned.

Time and place of the 1974 annual meeting has not yet been determined.

JOHN O. BUTLER, M.D.  
*Trustee*

JOSEPH F. FERRARA, M.D.  
*Trustee*

## Eighth Trustee District

HOUSE ACTION: Ordered Filed.



RICHARD INGRAM, M.D.  
*Trustee*

When this report is published, the 1973 Eighth District Medical Society Meeting will be history. This meeting, we hope, will usher in a new era of activity at the District level in the sense that a much larger percentage of members will have been present to carry out the business of the District. Any such increase in attendance will be due to the direct efforts of the District Society President Dr. David Dietz, and the fine evening program he has arranged.

It does seem important to me that more members are active in the medical political activities of our Medical Societies at all levels, since we are now in a time when changes are being politically



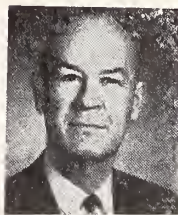
wrought in the practice of medicine which may actually alter the quality and availability of care for our patients forever. In this area, there are two general approaches to the problems of governmental interference in the practice of medicine, plus a third totally unacceptable approach. To dispense with the third approach first: It is the idea that nothing can be done, and all efforts are useless. This is a hopeless attitude and, therefore, unacceptable in my opinion.

Another frequently suggested approach to the problems concerning governmental interference in our practice of medicine is that we, ourselves, try to run and apply the proposed government programs, thereby somehow making them less punitive, and less likely to alter the patterns of care that we are used to. However, from experience we might well learn that in the past, when we have chosen to, in a sense, play ball with Government programs, we have continually been the loser, and great inroads have been made into the private nature of the contract between us and our patients. Therefore, in my opinion again, this approach is no longer feasible. The final approach, and the one most important in my opinion, is that we finally decide, as physicians, we do have a responsibility for the care of our patients, and a responsibility to keep that care private, to tell the Government that we no longer will participate in programs of control over the private contracts that take place between the doctor and the patient. I recognize that this is a difficult task to undertake. It takes a degree of unanimity that we have never had. But if ever the physicians are going to be able to unite in a solid front to preserve the practice of medicine, in the way we believe best to give quality care to our patients, now is the time to do it. I would urge, therefore, that physicians the state over think seriously about the problems that are coming up concerning governmental intervention in our practices. And if you think that this problem has reached such proportions that it is no longer possible to brook any interference in our practice by the government, then we should unite and do our best to practice medicine in the private fashion that we were used to doing, and refuse to participate in control schemes that are furthered by the politicians.

**RICHARD INGRAM, M.D.**  
*Trustee*

## Ninth Trustee District

**HOUSE ACTION: Ordered filed.**



**WILLIAM M. SHOLTY, M.D.**  
*Trustee*

The Ninth District meeting was hosted by the Fountain-Warren Co. Medical Society on June 14, 1973, at the Attica Hotel, Attica. The president Dr. Lowell Stephens, presided. Mr. James McNamara, an attorney from the AMA, gave the pros and cons of medical corporations and Keogh plans (HR 10).

Benton, Boone, Clinton, Fountain-Warren, Hamilton, Montgomery, Newton, and Tippecanoe Counties were represented. Tipton, Jasper, and White Counties did not have delegates present.

ISMA president, Dr. James Gosman, presented the plans for the convention to be held October 8, 9, 10, 11 in Indianapolis.

Mr. James Waggener, ISMA executive secretary; Herb Dixon, executive vice-president of Blue Shield; Dr. Thomas Tyrrell and Dr. K. O. Neumann, alternate AMA delegates; Dr. William Sholty, Ninth District Trustee; and Dr. Barton Bridge, Ninth District Blue Shield Representative were introduced.

Dr. Barton Bridge reported on the changes and progress taking place. Efforts to pay for more office procedures are being made. Many claims declared questionable in the past will be covered.

During the business portion of the meeting, Dr. William M. Sholty was nominated and elected Ninth District Trustee for a second term.

Drs. Peter Petrich and Barton Bridge were nominated for Ninth District Blue Shield Representative. Dr. Petrich was elected.

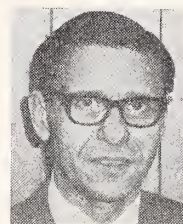
Socializing pressures seem to be always present from all directions. Rest assured that your ISMA is doing all it can to preserve the freedom of medical practice as it has been known in the past.

Next year's meeting will be hosted by Clinton County.

**WILLIAM M. SHOLTY, M.D.**  
*Trustee*

## Tenth Trustee District

**HOUSE ACTION: Ordered filed.**



**VINCENT J. SANTARE, M.D.**  
*Trustee*

The Tenth District Meeting was in May 1972, at which time Dr. Dimitroff was re-elected president of the Tenth District; Dr. Mansueto was elected secretary; Dr. Martin O'Neill was elected alternate trustee; and Dr. William Fitzpatrick was elected Blue Shield Board Representative.

The meeting this year is to be held in September 1973, at the Lake of the Four Seasons. There are no elections to be held this year. Both Lake and Porter Counties have a good representation in the Calumet Foundation for medical care, the President of which is Dr. Lee Trachtenberg. The Foundation has been established in order to qualify as a PSRO organization, when the time and circumstances are feasible.

Dr. Ramker continues as president of Lake County Medical Society, finishing his second year. Porter County is being served by Dr. McBride as president of the County Medical Society, and Dr. A. Kobak has been selected as president-elect, to serve as president in the year 1974.

**VINCENT J. SANTARE, M.D.**  
*Trustee*

## Eleventh Trustee District

**HOUSE ACTION: Ordered filed.**

**Recommendation: Item on unequal distribution of primary care physicians as related to specialty and sub-specialty physicians referred to Commission on Medical Education and Licensure.**



**JAMES A. HARSHMAN, M.D.**  
*Trustee*

The problems facing the district are the same that we have been facing for a number of years. By far the most serious problem is that of a lack of primary care physicians. Whether it is an actual shortage or merely a maldis-



tribution of physicians, the end result is the same. In a study completed a couple of years ago by the ISMA headquarters staff, the ratio of population to family practitioners was listed for each county of the state. In the 11th district the following ratios were found: Cass County, 3,517:1, Carroll County 1,901:1, Grant County 3,736:1, Howard County 4,741:1, Huntington County 3,227:1, Miami County 3,927:1, and Wabash County 1,972:1. For the entire district the ratio of population to family practitioner was 3,364:1. These ratios all exceed those for the national average.

Not much has happened in the past two years to change the picture. The family practice programs in the state are slow in getting started, and the demand far exceeds the supply. The problem is further compounded by the superspecialization that is occurring in the fields of internal medicine and pediatrics. No longer are general internists and pediatricians being trained, but rather hematologists, endocrinologists, oncologists, nephrologists, gastroenterologists, rheumatologists, cardiologists, etc. When an internist or pediatrician subspecializes, he is automatically committed to practice in a community of at least 100,000. Only a few communities in the state have this dense a population; thus leaving numerous smaller communities without internists and pediatricians. By necessity, the family practice programs are going to have to fill this void. Perhaps this is because the family practice department, which is in its infancy, is having too much competition from the established dynasties of the university for the appropriation dollar. Educators are going to have to face this problem more squarely than they have in the past, or they are likely to get "assistance" from persons outside the academic and medical communities.

There is growing concern among the physicians of the district about the increasing governmental intervention and interference into the private practice of medicine. One of the most profound of these governmental programs is to be found in P.L. 92-603, the PSRO. There is almost unanimous opposition to PSRO in the district. Now that it is law, the question really centers around what we are going to do about it. Our course of action will be determined by the House of Delegates. Our options are somewhat limited, but the decision as to what course to take may be one of the biggest decisions organized medicine will have to make for a few years to come.

I am a firm believer in the institution of the House of Delegates, and I believe that this decision should be made by those representing the "grass roots" of the medical community.

Another serious problem confronting the entire state is that of drug abuse. Practically everyone shares some responsibility in this problem, including the medical profession, law enforcement, parents, industry, schools, etc. Since the total community is involved and responsible, it will require total involvement of the community to find solutions. This includes the medical profession. The number of persons that abuse drugs is astronomical. There are increasing numbers of younger school children that are experimenting with drugs. Realism may be the first step toward solving the drug abuse problem instead of trying to scare it to death. The total community must join in this realism.

Publicity about drug abuse seems to have peaked, but the problem of drug abuse with all its ramifications has not yet begun to peak. Several years ago drug abuse was blamed on overprescribing physicians, or permissive parents whose medicine cabinets were filled with "appetite" pills and tranquilizers, on generation gaps, and on a sick society. Today we are less inclined to oversimplify the drug abuse problem. It is clearly more than a medically created problem. I know of no other profession aside from the medical profession whose input could be greater in helping a community find solutions to the drug abuse problem. In my own community of Kokomo, school administrators, law enforcement, industry and city officials have all asked for assistance from the medical profession. Although drug abuse is only one of several serious problems facing our society, it is clearly one which the medical profession can lend its expertise to.

Last September the 11th District Medical Society was hosted by the Howard County Medical Society in Kokomo at the Stellite Park. After an afternoon of golf, the members discussed legislative matters with Congressman Elwood H. Hillis. At the business meeting the following officers were elected: President: Joseph Bean, M.D., secretary-treasurer: Fred Poehler, M.D., ISMA trustee: James Harshman, M.D., ISMA alternate trustee: Lloyd Hill, M.D. (filling an unexpired term ending in 1974).

Grant County Medical Society will host the 1973 district meeting.

JAMES A. HARSHMAN, M.D.  
Trustee

## Twelfth Trustee District

HOUSE ACTION: Ordered Filed.



Wm. R. CLARK, SR.,  
M.D.  
Trustee

This is my last report to the ISMA and my 12th District. I have seen many changes in organized medicine in the five years that I was an Alternate Trustee and the past six years as a Trustee. The changes during this time have been tremendous. I can well remember when being on the Board was more or less a simple challenge compared to the problems of Medicare, Medicaid and health care as now presented.

To the constituents of ISMA, may I say these have been not only trying but revolutionary to what it was ten years, even six months ago. I have been accused of preaching in my own District—saying over and over that there was too much apathy on the part of the rank and file of all physicians. I am only sorry that every physician of the ISMA could not sit month after month with the Trustee Board in order to realize the great problems that are facing the physicians of our country.

May I say to you that the Commissions, Committees, Alternate Trustees, Trustees, Executive Committee, the State Officers, and your President are doing a yeoman job. It is unbelievable the number of hours they have given without remuneration or acclaim in behalf of the membership. I want to especially commend Mr. James Waggener and his staff. You will never know how dedicated Jim and his people are until you have had the privilege of observing their great efforts in our behalf.

I sincerely believe that the majority of the membership is not in favor of or happy with PSRO, HMO, and HEW. As a Trustee, I have not supported any of these above programs as I felt that it was not only an indictment but class legislation against the physicians of the United States. Why Congress does not select other professions or castes for its reprimanding, I am unable to understand. However, now that it is a law, I feel that the AMA, state and county officers should set up the guidelines as to how it is to be implemented, thereby not completely losing control of our own destiny.

I have had the privilege of visiting



many foreign countries and, without reservation, I state that our health care, the capability of our physicians and the patient-physician relationship is the best in the world. Let us try hard to keep it that way. The prospect of what will happen to the practice of medicine is still in the ova state and not determined. However, I want you to know that I sincerely believe it is in the good hands of your state, district and county officers.

May I add that it has been great privilege to have worked with some of the finest men I have ever known. I don't know who will be my replacement, as this article is being written prior to our annual district meeting but may I wish my successor great wisdom in his representation of the 12th District.

Last and above all may I thank the District for the great honor and trust they bestowed on me in representing them the past years.

With best wishes for the 12th District and the ISMA.

WILLIAM R. CLARK, SR., M.D.  
*Trustee*

## Thirteenth Trustee District

**HOUSE ACTION: Ordered Filed.**



G. BEACH GATTMAN,  
M.D.  
*Trustee*

The Thirteenth District Medical Society held its Annual Meeting in Michigan City, September 13, 1972. Due to inclement weather, the golf tournament was canceled. There was a moderate attendance at the business meeting where the report of the Trustee was given. In other business, Dr. James Rimel, Plymouth, was elected President, Dr. Jack Hannah, Elkhart, president-elect, and Dr. David Spalding, Mishawaka, re-elected secretary-treasurer. Dr. Francis Kubik, Michigan City, was elected to the Blue Shield Board to replace Dr. Edward Dovey of Elkhart.

Dr. Peter Petrich, president of the ISMA, Dr. James Gosman, president-elect ISMA, and Mr. James Waggener, ISMA Executive Secretary, were in attendance at our meeting.

The afternoon business session was concluded with a discussion of the proposed Medical Practice Act by Dr. Franklin Bryan and Dr. Merritt O. Alcorn. A question-and-answer period fol-

lowed.

The evening program following dinner was presented by the "Green Mountain Boys," M.D.s from Springfield, Missouri, who entertained us musically with originality and humor. A special plaque was given to Dr. Otis Bowen for his service to the 13th District.

Due to the illness of Dr. Frank McGue of Michigan City, president of the 13th District, president-elect Frank Rimel presided.

Our District has been active in formulating plans for District meetings which are to be held three to four times a year in conjunction with a regular meeting of one of the Counties in our District. It is hoped that the County officers and delegates will be able to attend these meetings along with other interested members of the District. The first of these was held by the St. Joseph County Medical Society in May 1973. Topics for discussion will no doubt include PSRO, HMO, and other subjects of interest to the membership.

The next meeting of the District will be September 12, 1973 in Plymouth, Indiana.

G. BEACH GATTMAN, M.D.,  
*Trustee*

## Editor of The Journal

**HOUSE ACTION: Ordered Filed.**

*The Journal* is operating within its budget this year. Due to the fact that revenue from national advertising accounts has been less than that for the same period last year by 35% it has been necessary to have smaller issues for most of the months since last report. Local advertising has been at a normal level.

The interest income of the Indiana Medical Foundation, Inc., has been allocated to *The Journal* and each year is utilized for artwork. As the Foundation grows, this financial aid will increase and provide improvements in publication.

In addition to an especially fine contribution of clinical articles, special papers on treatment of drug addiction, cancer chemotherapy, informed consent and the training of physicians' assistants have been featured.

The history of medicine in Indiana has been covered by tributes to Dr. Frank B. Wynn, the father of the medical scientific exhibit, and to Dr. Alfred Ralph, a dedicated pioneer physician.

The one special issue of the year was devoted to the Methodist Hospital of

Indianapolis and its graduate education program.

Another special feature was the publication of a report by John C. Johnson, a student at Indiana University School of Medicine, who conducted a unique and helpful study of physician needs in the state.

*The Journal* enters another year of publication with an ample supply of scientific material.

FRANK B. RAMSEY, M.D.  
*Editor*

## Delegates to AMA

**HOUSE ACTION: Ordered Filed.**

RUSSELL B. ROTH, M.D., BECAME AMA'S 128TH PRESIDENT during the annual convention in New York City, June 24 through 28. The Erie, Pa., physician has served for 20 years in various capacities with his county and state medical societies and with the AMA.

MALCOLM C. TODD, M.D., LONG BEACH, CALIFORNIA AND MEMBER OF THE CALIFORNIA DELEGATION was elected to the office of president-elect. E. Bryce Robinson, Jr., M.D., Birmingham, Alabama, was elected vice-president.

EUGENE E. SENSENY, M.D., FORT WAYNE, FLOOR LEADER FOR INDIANA DELEGATION, was unable to attend the session because of emergency surgery. James A. Harshman, M.D., Kokomo, was elected by the Indiana delegate body to handle the floor leader's responsibilities.

STATE DELEGATIONS CONSIDERED MORE THAN 164 RESOLUTIONS and a volume of reports from the AMA Board of Trustees and the Councils and Committees of the AMA.

PSRO REPORTS AND RESOLUTIONS RECEIVED CLOSE ATTENTION AND DELIBERATION but the broad variety of matters facing the delegate body included such topics as Phase III Fee and Wage Controls, patient's right to die in dignity, AMA membership in the World Medical Association, abortion, Medcredit, intern and resident delegate representation, drug abuse, sale of contraceptives, paramedical personnel, occupational safety, HMOs, Food and Drug Administration and intrusion in the practice of medicine.

WORKING LONG AND HARD TO COVER THE AREAS PRESENTED, the ISMA delegation caucused continuously to review reports and plan their actions in the House.



PRESENT FOR THE MEETING FROM THE DELEGATION BESIDES CHAIRMAN PRO-TEM HARSHMAN were Jack E. Shields, M.D., Brownstown; Lowell H. Steen, M.D., Hammond; Malcolm O. Scamahorn, M.D., Pittsboro. Alternates attending included Patrick J. V. Corcoran, M.D., Evansville; Thomas C. Tyrrell, M.D., Hammond; Ross L. Egger, M.D., Daleville, and Kenneth O. Neumann, M.D., Lafayette. Joining the delegation in their deliberations were Sprague H. Gardiner, M.D., Indianapolis, Section on Obstetrics and Gynecology; Lall G. Montgomery, M.D., Muncie, Section on Pathology and Myron H. Nourse, M.D., Section on Urology. President of ISMA, James H. Gosman, M.D.; President-Elect Joe Dukes, M.D.; Chairman of the Board Gilbert M. Wilhelmus, M.D., and Immediate Past President, Peter R. Petrich, also participated.

TEN REPORTS AND RESOLUTIONS ON PSRO CAME BEFORE THE HOUSE, among which were Resolutions 49, 107 and 150. Resolution 49 called on the Association to publicize the deleterious effect PL 92-603 could have on quality of care and to assign "highest priority" to developing and pursuing appropriate amendments to PL 92-603; Resolution 107 asked AMA to go on record as opposed to PSRO; and Resolution 150 asked for repeal. During the hearings, these resolutions called forth considerable emotional support from physicians attending, and strong criticism of the PSRO approach to review. The House adopted the following substitute resolution in lieu of the three.

"Resolved, That although it is recognized that repeal or modification of PSRO legislation ultimately may be required to preserve high quality of patient care, the American Medical Association should oppose any facets of this current legislation which act to the deterioration of quality care, publicize such deleterious facets, and place highest priority on developing and pursuing appropriate amendments to preserve high quality of patient care."

THE HOUSE ADOPTED A REPORT STATING THAT DUAL REPRESENTATION OF PHYSICIANS by unions and by their professional organizations would be divisive and counter-productive to the needs of the profession in dealing effectively with government and third parties. The report noted that, while physicians are entitled to join

unions, they can best achieve the goals of the profession "through carefully planned action programs of the AMA and its constituent and component societies." The House urged the Board to continue its interest in employee physicians but said it is "convinced that the interests of the great majority of the members of the Association, who are self-employed practitioners in private practice, are not best served by the policies and practices of organized labor."

SEVERAL ACTIONS WERE TAKEN TO ENCOURAGE AND FACILITATE MEMBERSHIP IN THE AMA. They amended the bylaws to provide that (1) physicians become AMA members upon certification by the state society rather than upon receipt of dues by the AMA, (2) the AMA dues-delinquency date be changed from June 1 to April 30, (3) payment of one year's past dues for reinstatement of AMA members be eliminated, (4) the criteria for AMA dues exemption be consistent with that of state societies, (5) the AMA

be permitted to bill directly for dues under certain circumstances.

FOOD AND DRUG ADMINISTRATION CAME UNDER STIFF CRITICISM through six resolutions. The resolutions asked the House to protest their regulatory activities. Among several resolves adopted to change some of the FDA practices was the following:

"That the American Medical Association continue to protest those proposed and current regulatory activities of the Food and Drug Administration which have the effect of restricting the use of prescription drugs to approved labeling recommendations or which threaten to interfere with the exercise of a physician's professional prerogatives in selecting the drug of choice for a patient."

JACK E. SHIELDS, M.D.  
LOWELL H. STEEN, M.D.  
JAMES A. HARSHMAN, M.D.  
EUGENE F. SENSENY, M.D.  
MALCOLM O. SCHAMAHORN, M.D.

REPORT OF BOARD OF MEDICAL  
REGISTRATION AND EXAMINATION OF INDIANA  
July 1, 1972, to June 30, 1973

<b>HOUSE ACTION: Ordered filed.</b>		Candidates from foreign medical and other schools taking State Board Examinations . . . . .	154
Applications received for December, 1972, June 1973 State Board Examinations (Med.) . . . . .	582	Candidates from foreign medical and other schools, failed . . . . .	102
Ineligible to take State Board Examination for various reasons . .	32	Candidates from foreign medical and other schools, who passed . .	52
Approved for December, 1972, June, 1973 State Board Examinations . . . . .	550	Over-all failure rate . . . . .	31.2
Failed to appear for State Board Examinations . . . . .	166	I.U.M.S. Graduate, failure rate . .	7.8
Applicants taking State Board Examinations . . . . .	384	Foreign medical school graduate, failure rate . . . . .	66.2
Candidates failed the State Board Examinations . . . . .	120	Candidates taking Chiropractic State Board Examination . . . . .	0
Candidates passed the State Board Examinations . . . . .	264	Candidates taking Physical Therapy Examinations . . . . .	48
Candidates from Indiana University Medical School taking State Board Examinations . . . . .	230	Candidates taking Physical Therapy Examinations, failed . . . . .	1
Candidates from Indiana University Medical School taking State Board and failed . . . . .	18	Candidates taking Physical Therapist's Assistants Examination, . .	8
Candidates taking Doctor of Osteopathy Examination . . . . .	5	Candidates taking Physical Therapist's Assistants Examination, failed . . . . .	5
Candidates taking Doctor of Osteopathy Examination, failed . . . . .	2	Candidates taking Podiatry State Board Examination . . . . .	4
		Candidates taking Podiatry National Board Examination, licensed	4
		Candidates, Podiatry, failed . . . . .	0



**TOTALS, LICENSED BY EXAMINATION**

	1969-1970	1970-1971	1971-1972	1972-1973
Medicine	355	284	287	264
Physical Therapy	23	41	43	47
Physical Therapist's Assistants	0	0	24	0
Podiatry	11	2	6	4
Osteopathy	1	0	0	3
Chiropractic	0	0	0	0
1970-1971	1971-1972	1972-1973		
Applicants granted license in Indiana by endorsement/reciprocity (M.D.)	184	265	253	
Applicants endorsed to other States (M.D.)	332	205	338	
Applicants granted license in Indiana by endorsement/reciprocity (Osteopathy)	5	13	13	
Applicants endorsed to other States (Osteopathy)	0	2	0	
Applicants granted Physical Therapy license in Indiana by Endorsement/reciprocity	20	18	26	
Physical Therapists endorsed to other states	7	16	20	
Applicants granted Chiropractic License in Indiana by endorsement/reciprocity	11	16	13	
Chiropractors endorsed to other States	0	0	0	
Applicants granted Podiatry license in Indiana by endorsement/reciprocity	0	0	1	
Podiatrists endorsed to other States	1	1	1	
Total Investigations (All categories)	19	24	32	
Citations or Board Action during the year (all groups)	14	7	2	
Revocation during the year (all groups)	1	6	1	
Licenses reinstated (revocation and delinquent)	0	63	267	
Physicians, voluntarily surrendering their Narcotic Stamp to the Internal Revenue Department	0	3	3	

**TOTALS, BOARD LICENSURE:**

	1970-1971	1971-1972	1972-1973
M.D. (resident and non-resident)	8,248	8,617	8,739
D. O. (resident and non-resident)	271	279	283
Drugless (resident and non-resident)	140	143	104
Chiropractic (resident and non-resident)	342	349	349
Physical Therapy	379	410	525
Fodiatry	212	214	205
Midwife	3	4	4
Physical Therapist's Assistants	0	24	25
Temporary Physical Therapy Permits issued	3	4	3
Temporary Medical Permits issued	28	14	29
Internship Permits issued	102	116	111
Temporary Medical Educational Permits issued	44	45	48
Temporary Physicians Permits Issued	31	89	64
Medical Teaching Permits Issued	5	8	2
Total Medical Corporations Licensed in Indiana	305	517	713
Total Chiropractic Corporations Licensed in Indiana	0	1	3
Total Podiatry Corporations Licensed in Indiana	0	1	1

# Reports of Committees

**Executive Committee**

**HOUSE ACTION: Ordered Filed.**

The Executive Committee met for organizational purposes immediately following the Board of Trustees' organization meeting on October 18, 1972.

By secret ballot Donald M. Kerr, M.D. was re-elected chairman of the Executive Committee. Gilbert M. Wilhelmus, M.D., chairman of the Board of Trustees, Vincent J. Santare, M.D. and Arvine Popplewell, M.D., the new assistant treasurer, were welcomed to membership on the committee.

The signing of bank cards and other organizational matters of the committee

were handled and the committee adjourned to meet again on November 18, 1972.

The Executive Committee convened at the headquarters building on November 18 and discussed the rendering of services to the IMPAC organization, discussed the problems the doctors were having with Aetna Insurance Company, approved the South Pacific tour for the members of the Association, reviewed the opinion of legal counsel concerning liability under the Tel-Med program, reviewed the AMA action on residents and interns, authorized representation of the Association at the AMA Leadership Conference, and reviewed the financial statements of the Association.

The Executive Committee was called to order by Dr. Kerr on December 17, at 9:30 a.m., with full attendance and Charles A. Bonsett, M.D., as a guest.

Dr. Bonsett appeared before the committee for the purpose of discussing the action of the House of Delegates concerning the conversion of the old Pathology Building at Central State into a medical museum. It was agreed the president would appoint a committee to meet with Dr. Bonsett and his committee to try to finalize some action on this project.

Reviewing the membership report, the committee decided to recommend to the trustees that they institute a membership drive in their respective districts to increase membership in both the ISMA and the AMA.

The committee authorized repairs to be made on the building for a leaky water line which was destroying the plaster in one of the offices.

They also reviewed the report of the Medical Exhibitors Association concerning the reaction of the exhibitors at the 1972 meeting.

They also reviewed the report of the financial affairs of the Association, renewed membership in the Better Business Bureau and in WA-SAMA.

In addition to other housekeeping matters, they reviewed the matters of the Joint Medical Advisory Committee of the Blue Cross-Blue Shield, as well as matters of the Executive Committee of the Mutual Hospital Insurance.

They approved attendance at the 1973 Legal Symposium held at Las Vegas. Representing the Association were Drs. Wilhelmus, Dukes and Santare.

They approved representation of ISMA at the Medical Congress on Medical Education and approved the representative from the Commission on Special Activities to attend the Rural Health Conference, and set the date for the an-



nual visitation of the congressional delegation.

The committee then adjourned as an Executive Committee and reconvened as a budget committee of the Association to review the proposed budget. The budget was approved upon motion by Dr. Hugh Thatcher, seconded by Dr. James Gosman.

The Executive Committee met at the headquarters building on January 20, 1973, and heard a report from the executive secretary that consideration should be given to future planning needs, inasmuch as all available space in the headquarters building is now occupied.

Dr. Gilbert Wilhelmus was appointed chairman of a travel committee for the Association.

They heard a report from the federal government congratulating the ISMA on its handling of the CHAMPUS program.

In addition to many housekeeping matters, the president was authorized to establish a membership committee to be chaired by Past President Dr. Peter R. Petrich.

The Executive Committee also took action to recommend several Indiana physicians for membership on the AMA councils and committees.

The committee turned down a request to co-sponsor an Institute on the Quality Assurance Program developed by the American Hospital Association.

The committee noted, in a report from the State Medical Journal Advertising Bureau, that Editor Frank Ramsey, M.D. of the Indiana Journal had been re-elected president of the board of directors.

Approval was granted for the Commission on Public Information to attend an annual Congress on the Socioeconomics of Health Care.

The chairman of the Commission on Aging was authorized to attend the meeting on The Role of the Medical Director in the Long-Term Care Facility.

The Executive Committee met on Saturday, February 17, at the Marriott Inn in Chicago. Guests at this time were Dr. Wood, AMA trustee, and Dr. Sprague Gardiner of Indianapolis.

The committee reviewed the Supreme Court decision on abortion and the committee decided the Association should take no part in sponsoring legislation on this subject. This was also reaffirmed by President Gosman's statement on abortion confirming the official policy of the AMA as being that of ISMA.

Plans for the County Society Officers' Conference for March 11 were reviewed

and approved.

The secretary raised a question of certificate of need legislation and pointed out the deleterious effect upon physicians. He proposed some recommended changes in the bill, which were approved; and if the amendments were not successful, opposition to the measure would be expressed.

The secretary reported the CHAMPUS program for the year 1972 exceeded one-million dollars paid to the physicians of Indiana.

The secretary reported to the committee the discussion which he had with the secretary of the Florida Medical Society concerning their professional liability plan. By consent, it was agreed that the matter be referred to the Commission on Medical Economics and Insurance for further study and investigation.

The committee reviewed proposed changes in the constitution and bylaws of the Indiana Chapter of the American Association of Medical Assistants.

The committee replied to the request from the Department of HEW to submit names of three physicians from Indiana who are knowledgeable in utilization review, as possible members of the Regional Advisory Committee.

The secretary presented materials left in his office by a representative of the Social Security Administration with regard to the PSRO. Following a lengthy discussion of this matter and the implementation of Sections 207 and 237 of the law by the State Welfare Department, it was moved to refer this matter to the Future Planning Committee to draw up a plan on Foundations to present to the Board of Trustees for their review.

The Executive Committee convened at the headquarters office on Saturday, April 14, and heard a report from the executive secretary as to the four weeks of operation of Tel-Med, receiving 10,196 calls.

The committee referred to the Board of Trustees a question of a policy on membership of public health physicians doing a tour of duty in the state of Indiana.

The secretary reported on two organizations coming into the state with mobile units and doing multiphasic screening of union groups. He pointed out that the question of legality had been referred to the Indiana State Board of Medical Registration and Examination and to the Indiana State Board of Health; but, according to their replies, there is apparently nothing that these two boards can do to stop this operation.

The committee heard a reply from the

Deputy Attorney General concerning the right of the Board of Medical Registration and Examination to suspend a physician's license and this correspondence was referred to the Medical Disciplinary Committee of the Board of Trustees.

The committee authorized the filing of an amicus curiae brief for a lawsuit against a physician in Lake County.

The secretary read a letter from the attorney concerning a physician's responsibility in the Workman's Compensation Act and this was ordered to be reproduced in the News Flash.

A resolution for presentation to the AMA House of Delegates concerning a class action suit was referred to the Board of Trustees, as was a resolution proposed by the Commission on Special Activities.

The secretary announced that he had received a check from AMA-ERF in the amount of \$21,534.45.

A letter from the Indiana State Board of Health concerning new government regulations on amphetamine combinations and their recall was reviewed for the information of the committee and this is to be widely disseminated among members of the Association.

The attendance of S. O. Waife, M.D., as Indiana representative to the U. S. Pharmacopeial Convention was authorized.

The president was authorized to name a representative to attend the meeting of the Regional Home Health Conference.

The committee convened at the headquarters office at 2:00 p.m., Saturday, May 19 for transaction of its usual business.

Renewal of the lease on the rental property owned by the Association was approved.

Authorization was given to correct a leak in the foundation of the east wall of the building.

The treasurer reviewed his report of the investment of surplus funds in operations of the Association.

The committee approved an official statement from the Association on the viability of a fetus. This statement was requested by the State Board of Health.

The secretary reported on the activity of the Retail Credit Bureau in contracting its services with insurance carriers to obtain copies of patients' medical records from physicians in the state of Indiana. This matter was referred to the Board of Trustees for their information and action.

A report was received from the representative at the U.S.P. convention.



The committee advised the T. B. Respiratory Disease Association that it was felt their intended publication should not list the names of certain physicians as counsel to patients having this disease.

The result of the Physician-Faculty-Student Retreat in which the students recommended the establishment of an assessment committee to determine the community need for a physician was discussed, and Dr. Gosman was given permission to refer this matter to the Subcommittee on Rural Health (Commission on Special Activities).

They approved a request from the Commission on Public Information for a pamphlet on venereal disease to be distributed by Blue Cross-Blue Shield.

They approved the attendance of Dr. Gosman, Dr. Dukes, and the executive secretary at a special meeting called by the AMA.

They approved the guest list for the 1973 annual meeting and reviewed the outline of the program for the meeting.

Several matters dealing with Blue Cross-Blue Shield were also reviewed.

It might be pointed out that this is only a scanning review of the activities of the Executive Committee. The complete minutes for each of the meetings are in the hands of the Reference Committee for their review. The minutes have also been published regularly in THE JOURNAL for review by the general membership.

Medical Defense Activities

1. Malpractice Cases. A year ago at the time of this report, August 1, 1972, the following four cases were pending before the committee:

Case 307 — Suit filed March 22, 1962. Pending. (Expense to date, \$1,042.73)

Case 313 — Suit filed September 5, 1967. Pending (Expense to date \$600.00)

Case 314 — Suit filed approximately July 6, 1970. Pending.

Case 316 — Suit filed July 2, 1970. Pending.

Since August 1, 1972 and to August 1, 1973, three new cases have been filed.

2. Medical Defense Fund Statement from August 1, 1971, to June 30, 1973;

Bank Balance,	
August 1, 1972	\$16,963.11
Receipts	5,086.55
Total Cash and Receipts,	
June 30, 1973	\$22,049.66
Disbursements	2,158.60
Balance on hand,	
June 30, 1973	\$19,891.06

The Journal

Listed below is a comparative report of The Journal operations over the past several years and the first six months of 1973, as follows:

The first table shows the number of journal pages for the past six years (includes inserts).

Year	Reading	% Reading	Adv. Pages	% Adv. Pages	Total Pages	Av. No. Pages Per Issue
1967	1041	58	751	42	1792	149
1968	1068	61	696	39	1764	147
1969	1041	67	509	33	1550	129
1970	1131	74	403	26	1534	128
1971	970	70	426	30	1396	116
1972	933	69	433	31	1366	113

The table below shows the total printing costs of The Journal:

Year	Total Printing Costs	No. of Pages (Inserts Excluded)
1968	\$50,709.62	1462
1969	42,916.62	1312
1970	44,520.84	1346
1971	40,542.21	1232
1972	41,789.70	1106
1973 (6 mos.)	22,307.25	526

A comparison of advertising revenues for the first six months of the last four years, with a like figure for 1973, is as follows:

Year (Jan.-June)	Sold by State Medical Journal Adv. Bureau	Sold direct By Journal	Total
1969	\$17,086.59	\$2,557.80	\$19,644.39
1970	15,791.12	2,268.80	18,059.92
1971	13,128.30	1,821.89	14,950.19
1972	17,869.96	1,622.60	19,492.56
1973	10,938.94	2,134.95	13,073.89

Membership Report

Total Members		
	December 1971	December 1972
ISMA	4,554	4,587
AMA	4,293	4,246
	July 31, 1972	July 31, 1973
ISMA	4,526	4,625
AMA	4,179	4,292

DISTRICT REPORT AS OF JULY 31, 1973

District	+ Gain - Loss	
	ISMA	AMA
1	+12	+ 6
2	+14	+14
3	- 2	-
4	+ 4	+ 7
5	+ 8	+ 6
6	+ 4	+ 4
7	+16	+36
8	- 6	- 9
9	+18	+13
10	+ 1	+ 4
11	- 2	- 4
12	+15	+17
13	+17	+19
	+99	+113

DEATHS

December 1972	52
As of July 31, 1973	22

COUNTY/DISTRICT MEMBERSHIP REPORT

	Dec. 31, 1972 ISMA	July 31, 1972 ISMA	July 31, 1973 ISMA	July 31, 1973 AMA
1st DISTRICT				
Gibson	11	11	11	11
Perry	7	7	7	7
Pike	2	2	2	2
Posey	6	6	6	6
Spencer	5	5	5	5
Vanderburgh	264	256	268	249
Warrick	6	6	6	5
TOTAL	301	293	305	285

2nd DISTRICT

Daviess-				
Martin	18	18	18	13
Greene	16	16	16	12
Knox	41	41	45	43
Owen-Monroe	95	89	96	84
Sullivan	10	10	13	12
TOTAL	180	174	188	164

3rd DISTRICT

Clark	54	53	53	46
Dubois	26	26	23	21
Floyd	44	44	46	44
Harrison-				
Crawford	9	9	9	9
Lawrence	37	37	37	31
Orange	8	8	6	6
Scott	7	7	8	8
Washington	7	7	7	7
TOTAL	192	191	189	172



## 4th DISTRICT

Bartholomew-				
Brown	61	61	64	52
Dearborn-				
Ohio	15	15	15	14
Decatur	10	10	10	9
Jackson-				
Jennings	19	19	21	21
Jefferson-				
Switzerland	29	29	28	25
Ripley	11	11	11	8
TOTAL	145	145	149	129

## 5th DISTRICT

Clay	12	10	15	15
Parke-				
Vermillion	15	15	14	14
Putnam	18	18	20	20
Vigo	120	119	121	115
TOTAL	168	162	170	164

## 6th DISTRICT

Fayette-				
Franklin	16	16	18	17
Hancock	27	27	25	25
Henry	38	38	38	33
Rush	12	12	12	12
Shelby	21	21	20	17
Wayne-Union	71	70	75	68
TOTAL	185	184	188	172

## 7th DISTRICT

Hendricks	22	22	23	19
Johnson	36	36	36	33
Marion	1093	1075	1090	1083
Morgan	21	21	21	19
TOTAL	1172	1154	1170	1154

## 8th DISTRICT

Delaware-				
Blackford	132	128	127	96
Jay	16	16	17	12
Madison	108	108	103	75
Randolph	17	17	16	10
TOTAL	260	269	263	193

## 9th DISTRICT

Benton	10	10	9	8
Boone	18	18	16	15
Clinton	14	14	15	12
Fountain-				
Warren	11	11	12	11
Hamilton	14	14	17	13
Jasper	8	8	9	9
Montgomery	23	22	24	24
Newton	5	5	5	5
Tippecanoe	144	142	154	141
Tipton	11	11	10	10
White	7	7	9	7
TOTAL	265	262	280	255

## 10th DISTRICT

Lake	454	450	440	407
Porter	64	67	78	76
TOTAL	523	517	518	483

## 11th DISTRICT

Carroll	8	8	8	8
Cass	35	35	32	26
Grant	79	79	79	77
Howard	71	70	72	69
Huntington	18	18	16	15
Miami	13	13	13	13
Wabash	29	29	30	22
TOTAL	253	252	250	230

## 12 DISTRICT

Adams	12	12	12	12
Allen	312	311	317	292
DeKalb	19	19	19	15
LaGrange	11	11	11	9
Noble	12	12	14	13
Steuben	10	10	13	13
Wells	46	40	44	44
Whitley	15	15	15	15
TOTAL	437	430	445	413

## 13th DISTRICT

Elkhart	111	111	114	104
Fulton	7	7	8	7
Kosciusko	12	12	13	13
LaPorte	94	93	101	86
Marshall	20	20	19	18
Pulaski	5	5	4	1
St. Joseph	239	237	243	242
Starke	8	8	8	7
TOTAL	496	493	510	478

## SUMMARY

1st District	301	293	305	285
2nd District	180	174	188	164
3rd District	192	191	189	172
4th District	145	145	149	129
5th District	165	162	170	164
6th District	185	184	188	172
7th District	1172	1154	1170	1154
8th District	273	269	263	193
9th District	265	262	280	255
10th District	523	517	518	483
11th District	253	252	250	230
12th District	437	430	445	413
13th District	496	493	510	478
	4,587	4,526	4,625	4,292

DONALD M. KERR, M.D.,  
Chairman  
VINCENT J. SANTARE, M.D.  
JAMES H. GOSMAN, M.D.  
JOE DUKES, M.D.  
GILBERT M. WILHELMUS, M.D.  
HUGH K. THATCHER, JR., M.D.

## Grievance Committee

## HOUSE ACTION: Ordered Filed.

The Grievance Committee has held only one meeting during the year, which is an indication to the members that more complaints are being handled at the local level, and the county medical societies are to be commended for this. As previously reported, the most prevalent complaints received by the committee are those of misunderstanding of charges by the physicians and the lack of communications between the patient and the physician.

As of July 15, 1973, 13 new cases were filed, 4 of which have been referred to the local county medical society. The other nine cases have been handled in a routine manner and have been resolved in a satisfactory manner.

The ISMA Grievance Committee continued to follow the procedure of past years. (1) Receipt of complaint is acknowledged by a letter which states that action can proceed only after receiving the complainant's permission to forward a full copy of the complaint to the physician or physicians named therein along with identification of those filing the complaint. (2) Should the requested permission be given, the physician named is asked to attempt a personal settlement of the complaint. (3) Should the physician be unsuccessful or should he request that his county medical society attempt settlement, the matter is so referred, with the ISMA Grievance Committee retaining the responsibility as the rules governing it require. A greater attempt is being made at the local level to settle differences before the state committee is involved.

The revised Purposes, Rules and Procedure of the Grievance Committee, as mandated by the 1967 House of Delegates, has been sent to every member of the ISMA and is sent to physicians when they become members of ISMA.

The Grievance Committee wishes to thank the members of ISMA who have been called upon to assist in discharging its responsibility. We have received excellent help.

RICHARD S. BLOOMER, M.D.,  
Chairman

WILLIAM D. PROVINCE, M.D.

EUGENE S. RIFNER, M.D.

KENNETH WILHELMUS, M.D.

THOMAS C. TYRRELL, M.D.

WILLIAM C. STRANG, M.D.

HARRY L. CRAIG, M.D.

LAWRENCE K. MUSSELMAN, M.D.



## Future Planning

### HOUSE ACTION: Referred to Board of Trustees for information.

Your Future Planning Committee had scheduled four meetings for the year 1972-73. For a variety of reasons two meetings were held and both were well attended. These meetings were held on January 20th and March 10th of 1973. The Future Planning Committee again voted unanimously to recommend to the Board of Trustees that the ISMA headquarters be enlarged. Survey of the headquarters indicates that there is no available space for additional activities, yet ongoing activities continually occupy more and more of the existing space, and, as previously recommended, if planning does not progress, we will find ourselves in a position where it is imperative to implement a program for which there is no available space. The Board of Trustees was again requested to establish a new building committee to begin planning for accommodation of the continuously escalating activities.

The Committee undertook a review of the testimony given to the Special Reference Committee Meeting held during the annual convention of 1972. It was the consensus of the Committee that the open hearings were primarily ventilatory in nature, but of very significant value to both the officers, Board of Trustees, and membership. It was difficult to find positive suggestions upon which the Future Planning Committee could make recommendations. There were a number of valuable suggestions, all of which have been referred to the Board of Trustees for evaluation. Further details of recounting of these suggestions is contained in the minutes of the Future Planning Committee, and are on file at the headquarters office.

It is recommended that at least every other annual session have a special reference committee to hear the testimony of any member of ISMA who desires to attend this special committee. Resolution No. 4 is submitted for consideration of the House.

The Future Planning Committee also has studied in great detail Public Law 92-603 (which embodies the concept of PSRO). It was the unanimous opinion of The Future Planning Committee that ISMA should obtain legal counsel and prepare a charter for a foundation that would encompass the areas that would serve as an umbrella PSRO, should the House of Delegates vote to proceed with further co-operation with this law. This

matter was referred to the Board of Trustees for further consideration.

It is doubtful that the current structure of the Future Planning Committee can be of great value to the officers and Board of ISMA, with its current composition. It is strongly recommended that at least 80% of the members of The Future Planning Committee be members of the Association that have been in practice less than five years. It is recommended that at least one past-president be a member of the Future Planning Committee, and that should be one who has served within five (5) years of the appointment for which he will serve on the Committee. We believe it imperative that continued input from the president, president-elect, and board chairman be available on an ex-officio basis, as is possible.

LOWELL H. STEEN, M.D.  
*Chairman*  
GEORGE M. HALEY, M.D.  
MAURICE E. GLOCK, M.D.  
JAMES FITZPATRICK, M.D.  
RALPH V. EVERLY, M.D.  
STANLEY CHERNISH, M.D.  
PATRICK J. V. CORCORAN, M.D.  
PETER R. PETRICH, M.D.  
DeWAYNE HULL, M.D.  
JAMES T. ANDERSON, M.D.  
JAMES H. GOSMAN, M.D.  
JOE DUKES, M.D.  
GILBERT WILHELMUS, M.D.  
DONALD KERR, M.D.  
FRANK B. RAMSEY, M.D.

## Student Loan Committee

### HOUSE ACTION: Ordered Filed.

The Student Loan Committee had no requests for loans, and consequently made no new loans during the past year. To date, 108 loans, totalling \$95,500, have been granted. Actually, 18 loans this year were converted to installment loans for a total of \$18,548.25. No notes are in interim. All are moving well.

The loan fund of ISMA from 1955 to 1963 had loaned money to 118 students, in all, a total of \$58,458.36. This total amount has been repaid. The Guaranteed Loan Plan with Indiana National Bank was started in December of 1963, and has on deposit \$20,810 of ISMA money. This guarantees loans up to \$260,000.

The general good economic situation of Indiana and the financial support of the students, because of working wives, and the fact that medical student jobs are good paying have minimized the

need for student loans. AMA-ERF is a common source of loans for students, and these loans are available through the medical school dean's office and his AMA-ERF representative.

MALCOLM O. SCAMAHORN, M.D.,  
*Chairman*  
JAMES H. GOSMAN, M.D.  
GILBERT M. WILHELMUS, M.D.  
VINCENT J. SANTARE, M.D.  
HUGH K. THATCHER, JR., M.D.  
GLENN W. IRWIN, JR., M.D.

## Medical Legal

### HOUSE ACTION: Ordered Filed.

The Medical-Legal Review Committee met February 4, 1973, in the headquarters of the Indiana State Medical Association with the chairman, John W. Beeler, M.D. and Joseph G. Weber, M.D. in attendance. Meeting with the Committee were President James J. Stewart, representing the Bar Association. There was considerable discussion about the advantages of forming some type of medical-legal review committee in those cases of alleged malpractice. The various state organizations currently having some type of joint review were discussed with special emphasis on the "Virginia Plan." It was decided to investigate this plan further, as to its function and to obtain suggestions from them regarding its implementation in Indiana.

Mr. Stewart agreed to obtain information from the Insurance Commissioner of the state of Indiana as to the number and types of malpractice cases over a one-year period in Indiana, so that we may obtain some actual data as to the problem as it currently exists in our State.

In addition, an experience of the San Francisco plan of medical-legal review is currently being investigated and the chairman has accumulated some early material, which hopefully will be augmented further by the last of this year.

Dr. Gosman urged obtaining data such as that requested from Mr. Stewart so that both physicians and attorneys, working together, may draft such legislation as necessary, if the proposed "Joint Medical-Legal Plan for Screening Medical Malpractice Cases" is adopted by the Society.

In addition, the Committee reviewed a complaint which had been referred to it, and the action of the Committee was to refer the complaint to the Grievance Committee of the ISMA.

The Committee also participated in a joint medical-legal program of the Mari-



on County Medical Society and the Indianapolis Bar Association, which was presented to the two societies in November 1972. The attendance at this program indicated the interest of members in the Professional Liability situation, and there are both local and state plans for further joint meetings.

The Chairman of this Committee was personally disappointed in the report of the Secretary's Commission on Malpractice, which was presented early this year. There are very few indications that the current trend of increasing number of suits and inappropriate financial judgments will alter in any way in the future.

#### RECOMMENDATIONS:

- 1) Evaluate the size of the malpractice problem which currently exists in Indiana with the help of the State Bar Association.
- 2) Select a Joint Medical-Legal Plan for Screening Malpractice cases, such as is now being used in some other state in a satisfactory manner (i.e. Pima County Plan of Arizona, the plan currently used by the Medical Society of Virginia).
- 3) Plan a joint meeting with the Marion County Medical Society and the corresponding societies of the State and Marion County Bar Associations for the fall or early winter of 1973-1974.

JOHN W. BEELER, M.D., *Chairman*  
JOSEPH G. S. WEBER, M.D.  
ROBERT R. KOPECKY, M.D.  
GEOFFREY SEGAR  
JAMES J. STEWART  
JOHN T. HUME, III

## Sports and Medicine

### HOUSE ACTION: Ordered Filed.

For the fourth year, this Committee has met in order to provide more complete medical care to young athletes and athletic events in Indiana, and to better coordinate and study certain aspects of the provision of care to Indiana's athletes. Therefore, this Committee has met and discussed with officials of the Indiana High School Athletic Association and representative coaches many topics regarding health and care of athletes under their jurisdiction. Informally in our meetings, many medical suggestions have been made regarding different training and competitive techniques, and also what can be done to improve these.

More directly, the Committee on Sports and Medicine has accomplished some of the following.

A Directory was assembled comprising nearly 300 physicians throughout the state of Indiana who have a special interest in athletic medicine. A questionnaire is now being formulated and will be sent to these physicians in order to learn of their qualifications, educational background, and activities in sports medicine. This directory is hoped to be a resource from which our Committee can expand and gain insight on particular problems around the state in athletic medicine. This directory might also serve to help local communities solve problems in athletic medicine by having some qualified person designated to assist them.

A meeting of one half day was planned by this Committee for the football coaches of Indiana to be held in July 1973 in conjunction with their meeting in Bloomington. This program will deal with facets of athletic injuries that can be both educational and helpful to these particular coaches. Additionally, a program to coordinate meetings regarding sports medicine throughout the state is in progress. This will afford doctors interested in sports-medicine an opportunity to attend meetings on athletic medicine in their particular areas once or twice yearly. New and varied topics of athletic medicine can then be introduced.

The main topic of discussion at our meetings was that of athletic training and how the ISMA can help improve the level of athletic training in high schools, and how we should proceed to require high schools to employ athletic trainers qualified to take care of athletic injuries. The Committee is investigating numerous avenues to approach this problem. It was thought by the Committee that legislative steps should be taken to encourage each high-school to staff its athletic department with one qualified trainer. Any method which can be used to gain this goal should be instituted. The Committee, however, will recommend to the Indiana State Commission of Higher Education, and the superintendent of the Department of Public Instruction of the state of Indiana, that:

"An educational program be developed in all Indiana teacher training institutions to educate and develop athletic trainers" (Resolution 71-13 House of Delegates ISMA 1971). The Committee feels, however, because of the immediacy of the situation, we should encourage training of students and teachers in our

secondary schools to act in the capacity of athletic trainers under the guidance of a team physician. Individual training should be done through means of athletic training seminars and summer camp programs, such as being conducted by the Kramer Company, which sponsors such workshops throughout the country. The Committee and the Indiana State High School Athletic Association will work jointly to provide the latter two programs in the following year.

The Committee on Sports and Medicine helped this year to formulate and endorse the new physician-student health certificate that is required by the IHSAA for all of its member schools' participants in athletics.

Recommendations made by this Committee in 1972-73:

1. A physician will be appointed to act as medical advisor to each of the 10 major sports of the Indiana State High School Athletic Association, and act as liaison between his sport and the Committee on Sports and Medicine.
2. That county medical societies sponsor one-day meetings yearly to acquaint physicians with new ideas in sports medicine.
3. That the "crack-back" block be completely eliminated from high school level of football.
4. In all all-star games the players be allowed to use their equipment from high school. Injuries should decrease with proper fitting of the equipment previously found satisfactory by the player.
5. That the football be allowed as part of the equipment for the three day pre-season training for football.
6. "Wrestle Backs" that require wrestling up to five times a day for individual participants is too excessive, and this policy should be altered.
7. Present practice requirements by the IHSAA should remain unchanged, and women's sports should adhere to the same schedule.
8. That the same particular care taken for the prevention and treatment of injuries to male athletes be afforded to female athletes.

BRAD BOMBA, M.D.,

*Chairman*

THOMAS A. BRADY, M.D.  
JAMES H. BELT, M.D.  
GILBERT M. WILHELMUS, M.D.  
ARTHUR L. MOSER, M.D.  
GARLAND D. ANDERSON, M.D.  
LESLIE M. BODNAR, M.D.  
ALOIS E. GIBSON, M.D.



JERALD E. SMITH, M.D.  
WILLIAM B. FERGUSON, M.D.  
PAUL MACRI, M.D.  
CHARLOTTE H. KERR, M.D.  
BOB OTOLSKI  
WARD BROWN  
PHIL N. ESKEW

# Reports of Commissions

## Convention Arrangements

**HOUSE ACTION:** The scientific program and exhibits constitute the report of this commission. Efforts of commission members are commended. Filed.

## Aging

**HOUSE ACTION:** Report and Resolutions contained in report Adopted. Recommendation: All members of the House of Delegates and ISMA become familiar with the Physician's Statement as it pertains to Medicare and Medicaid.

Your Commission on Aging this year undertook the task of trying to reach some solutions to the problems in the Medicare and Medicaid systems.

We first met with a number of key people, including E. Frank Ellis, M.D., director of Health for Region Five of the Department of Health, Education, and Welfare.

Following that meeting, your Commission held several meetings and drafted a position statement which was endorsed by the ISMA Board of Trustees.

The text of that statement follows:

### Position Statement on Medicare and Medicaid of the Commission on Aging of the Indiana State Medical Association

Economic realities and personal and professional frustrations may drive some physicians away from the care of Medicare and Medicaid patients and both programs could eventually become empty promises for lack of doctor participation.

Unless the situation is reversed and some sensible and acceptable arrangements are made to correct what presently borders on chaos, there will be fewer doctors willing to provide care for Medicare and Medicaid patients, much as they would like to do so.

Doctors, in increasing numbers, are refusing to be discriminated against as providers. Perhaps the public and politicians are not presently interested; but to the physician, who is a taxpayer trapped between rising expenses and Medicare and Medicaid payments below what he normally charges, there is no alternative.

Only professional providers of services are expected to accept a forced discount of their charges and then, as taxpayers, to subsidize public assistance. No other provider is expected to purvey a quality product, to struggle through a maze of paperwork, confusion as to patient benefits, conflicting regulations, misunderstanding and misinformation and then to accept reduced payment.

Physicians have every right to object to such cavalier treatment and they are doing so. What, for instance, can the rationale be for reducing a fee for a nursing home visit from \$10.00 to \$1.56 or 48¢ or even 16¢, except to make the doctor the scapegoat for the programs' shortcomings under the guise of "cost containment"?

How can any physician be expected to provide adequate care for patients in extended care facilities under such a system? Physicians, as a group, by the very nature of their calling, have more than their share of altruism and they exercise it in many ways. But to suppose that they will give away their skill, knowledge and judgment because politicians have made commitments they cannot honor is not only unrealistic, it's absurd.

Secrecy, again under the guise of "cost containment," pervades the Medicare and Medicaid programs. Physicians cannot learn how the allowed fees are determined. To deny them such information is a situation which can only be founded on mistrust. Physicians cannot be blamed for refusing to participate under those terms when the system finally fails because it is unworkable. Such secrecy in a program involving public funds is ridiculous and probably unconstitutional, especially when payments to physicians are not uniform.

The Social Security Administration has stated that physicians' charges for services under Medicare have decreased from 1966 through 1971. We don't doubt it! We believe that it is because physicians have really subsidized the program in that their usual and customary fees have been reduced arbitrarily without credit for doing so. Physicians are being told "This is not allowed" and

"That is not allowed" by non-medical persons screening claims and reversing the opinions of physicians who are the only people trained and expected to provide proper health care.

The Medicare and Medicaid programs are heading for real trouble because physicians are withdrawing for the reasons set forth here, and other reasons.

We are interested in keeping physicians in the programs to give quality medical care to those who need it. The physicians will more likely stay, we submit, provided:

1. They are fairly compensated for the services they render based on reasonable fees geared to variations in the cost of living and established upon proper consultation with physicians.
2. The billing procedure is simplified.
3. Nursing home visits are approved on the basis of need and the need is decided by physicians and not by non-medical personnel.

We further submit that if a patient does not have his or her own personal physician, extended care facilities make ethical arrangements with private physicians or groups of physicians to provide quality medical care.

We further submit that if a patient does not have his or her own personal physician, provision should be made by the extended care facility for ethical arrangements with a physician or group(s) of physicians to provide quality medical care.

Only physicians can give Medicare and Medicaid patients the professional medical care they need.

It is the hope of the Indiana State Medical Association that, in the interest of patients under these government programs, recognition be given to the problems herein cited and appropriate steps taken to reverse the current trend.

We respectfully request the House of Delegates of the Indiana State Medical Association to consider the following resolution:

RESOLVED, THAT THE HOUSE OF DELEGATES OF THE INDIANA STATE MEDICAL ASSOCIATION HEREBY ENDORSES THE POSITION STATEMENT OF THE ISMA COMMISSION ON AGING RELATIVE TO THE MEDICARE AND MEDICAID PROGRAMS AND MANDATES THE COMMISSION TO CONTINUE ITS WORK TOWARD THE SIMPLIFI-



## CATION OF THE MEDICARE AND MEDICAID SYSTEMS IN THE BEST INTEREST OF THE AGED.

Your Commission also respectfully requests that the House of Delegates consider this resolution:

**RESOLVED, THAT THE HOUSE OF DELEGATES OF THE INDIANA STATE MEDICAL ASSOCIATION DOES HEREBY URGE THE ESTABLISHMENT OF A CHAIR OF GERONTOLOGY AT THE INDIANA UNIVERSITY SCHOOL OF MEDICINE IN THE INTEREST OF PROVIDING BETTER HEALTH CARE FOR GERIATRIC PATIENTS.**

At the time of the submission of this report your Commission on Aging is preparing to meet again with the same group of local, state and federal officials we met with February 4 to continue our work.

ALBERT M. DONATO, M.D.,  
*Chairman*

JOHN D. WILSON, M.D.

JOSEPH C. DUSARD, M.D.

A. W. CAVINS, M.D.

CLOYD L. DYE, M.D.

THEODORE R. HAYES, M.D.

W. MARTIN DICKERSON, M.D.

DANIEL RAMKER, M.D.

JAMES McLAUGHLIN, M.D.

NATHAN SALON, M.D.

PETER CLASSEN, M.D.

MRS. C. B. LADINE

## Constitution and Bylaws

### Bylaws

The Commission on Constitution and Bylaws is proposing the following changes in the Bylaws in order to carry out recommendations made to the Commission:

**HOUSE ACTION: Adopted.**

### Chapter IV, House of Delegates

Be It Resolved that Section 1 of Chapter IV of the Bylaws be amended by adding a new and additional paragraph to read as follows:

"Nominations for officers of the Association may be made at any meeting of the House of Delegates."

**HOUSE ACTION: Adopted as amended.**

Be It Resolved that Chapter IV, Section 2, of the Bylaws be amended by adding a new and additional paragraph between paragraphs one and two which will read as follows:

"All sections listed in Chapter III, Section 1, of these Bylaws shall be entitled to send to the House of Delegates each year one delegate or one alternate delegate without the power to vote."

**HOUSE ACTION: Adopted.**

### Chapter IV, House of Delegates

Be It Resolved that Section 2 of Chapter IV of the Bylaws be amended by striking the last sentence of the last paragraph and substituting the following:

"No one shall be entitled to a seat in the House of Delegates unless his credential card as a delegate or alternate, properly signed by the secretary of his county society, is presented to the Committee on Credentials at the time of the Annual Convention."

**HOUSE ACTION: Adopted as amended.**

### Chapter XXX, Reference Committees

Be It Resolved that Chapter XXX, Section 1, of the Bylaws be amended by striking the last sentence of the first paragraph and substituting the following:

"Appointments of these reference committees shall be made by the Speaker with the assistance of the President. Appointments shall be made in time for them to be published in THE JOURNAL and the Handbook prior to such Annual Convention."

**HOUSE ACTION: Adopted as amended:**

Be It Further Resolved that Section 1, Chapter XXX of the Bylaws be further amended by inserting after the word "President" in paragraph two, the words "with the assistance of the President." Paragraph two will then read, "The Speaker with the assistance of the President shall have the power to appoint substitutes from among the members present for absent appointees."

**HOUSE ACTION: Adopted.**

Be It Further Resolved that Chapter XXX, Section 1, of the Bylaws be amended by inserting the words "at least" after the word "of" and before the word "five" in paragraph three, line one.

JOHN M. RECORDS, M.D., *Chairman*  
BERNARD B. ROSENBLATT, M.D.

PAUL B. ARBOGAST, M.D.

ELI GOODMAN, M.D.

IVAN T. LINDGREN, M.D.

GLEN WARD LEE, M.D.

WALLACE A. SCEA, M.D.

WILLIAM J. MILLER, M.D.

GILBERT H. WHITE, M.D.

EVRETT SMITH, M.D.

WILLIAM B. HUGHES, M.D.

CHARLES PLANK, M.D.

MALCOLM WREGE, M.D.

LESTER RENBARGER, M.D.

GORDON S. FESSLER, M.D.

WALLACE C. HILL, M.D.

MRS. THOMAS JOHNSON

### Constitution

The following Constitutional amendments are being proposed for initial action in the 1973 House of Delegates. If adopted, they would then have to lay over for one year until final action could be taken in 1974.

**HOUSE ACTION: Adopted as amended.**

Article IV, Composition of the Association

Be It Resolved that Section 1 of Article IV be amended by striking the entire Section 1 as now printed and substituting the following:

Section 1. This Association shall consist of Active Members, Associate Members, Senior Members, Honorary Members, Disabled Members, Distinguished Members, Military Service Members, Public Health Service Members, Retired Members and members of the Indiana Chapter of the Student American Medical Association.

Be It Further Resolved that Section 4 of Article IV be renumbered Section 5 that a new Section 4 be substituted to read as follows:

Sec. 4. Student Members — Students who hold active membership in the Indiana Chapter of the Student American Medical Association shall have all the rights and privileges of this Association and shall select one delegate or one alternate delegate who shall have all the rights and privileges of the House of Delegates with the power to vote.

(Old Sections 5 through 8 be renumbered 6 through 9)

**HOUSE ACTION: Adopted as amended.**

Be It Resolved that Section 9 of Article IV of the Constitution be renumbered Section 11 and a new Section 10 be substituted to read as follows:

Sec. 10. Military Service Members and Public Health Service Members. Any physician who is actively engaged in the military service or public health service shall be eligible for membership in the Association with payment of reduced dues, they shall receive THE JOURNAL.



## HOUSE ACTION: Adopted as amended.

Be It Further Resolved that in addition to being renumbered Section 11, Section 9 of Article IV of the Constitution be amended to read as follows:

Sec. 11. Rights and Privileges of Members. Active members, intern and resident members, senior members, military service members, public health service members, disabled members, honorary members, student members and retired members shall have the same rights and privileges except as follows:

(a) Senior members shall not be required to pay membership dues in the State Association.

(b) If senior members desire to receive *THE JOURNAL* of the State Association, they shall pay the regular subscription price therefor.

(c) Senior members who desire the benefit of medical defense as provided by the Bylaws of this Association shall pay the amount stipulated in Section 2, Chapter XXXIV of the Bylaws for this coverage.

(d) Honorary members hereafter elected shall hold such membership as an honor and distinction and shall have the right to attend meetings of the Association. They shall have the privilege of participating in discussions but shall have no right to vote or to hold elective office. They shall not be required to pay membership dues in the State Association. Such honor may be conferred by the vote of the House of Delegates.

(e) All such disabled members, as defined in Chapter IV, Section 9, shall receive membership cards and *THE JOURNAL* of the Association without charge.

(f) Student memberships may be represented in the House of Delegates with all the rights and privileges and the power to vote. They shall be entitled to send one delegate and one alternate delegate who are members of the Indiana Chapter of SAMA. The delegate and alternate delegate are to receive *THE JOURNAL* of the State Association.

(g) Retired members who have chosen voluntary retirement from the practice of medicine before the age of 70 shall only be required to pay membership dues in the amount of one-half of the full membership dues applicable at the time of retirement.

## Governmental Medical Services

### HOUSE ACTION: Referred to Board of Trustees for their information.

The Commission held several meet-

ings and telephone conferences in the past year.

Mrs. John Stanley, Muncie, liaison representative from the Women's Auxiliary, has joined our meetings. We have been most pleased to have her join us in our deliberations.

CHAMPUS claims of unusual nature have been reviewed by the commission in meetings by telephone. In the state of Indiana the CHAMPUS program operates well and is highly regarded by the superior officers in Denver. We have had very few rebuttals on claims and from the decisions of the commission.

The State Rehabilitation Commission met with our commission and explained some of the programs on the disability insurance examinations, particularly in the specialty groups. We have yet to receive from them a statement as to what fees they will pay for special examinations above and beyond the first examination.

During the year we heard from many people. Mr. Wayne Stanton, director of the Public Welfare Department, met with the commission early in the year. At that time we were joined by the Commission on Legislation. Mr. Stanton brought to the commission some important information. He brought us up to date on the Medicaid program and stated for the year 1972 the largest amount paid in money was for nursing care, with pharmacy being second. The Indiana doctors received about 10.87% of the dollars paid out, which is about the same as in previous years. We were also informed that there are approximately eight to ten physicians in the state who appear to over-utilize the Medicaid program.

The question of "Who has set the usual and customary fee up to now?" was raised to Mr. Stanton, but the answer was most ambiguous. We could not get an answer as to who sets the usual and customary fee in the Medicaid program. Mr. Stanton informed the commission that the Welfare Department needs about two additional doctors to review the claims in the state. This is one reason why there is an existing backlog of claims for disability, etc.

Starting January 1974, Mr. Stanton informed us that there will be federalization of three programs—old age, aid to the blind, and aid to the disabled. This will increase by about 300% the number of persons given aid. *And for the first time* aid will be paid from Medicare to ages below 65. One bright hope: with this increase they must meet strict re-

quirements. The commission also learned that Indiana is one of the lowest payers to the number on welfare—less than one-half the national average.

Mr. Stanton gave us information about the small booklet that is available which explains quite well the differences between the Medicaid and Medicare programs. I believe this booklet has been mailed to many members of the ISMA. Much confusion still exists, and it is hoped that the ISMA, in mailing these booklets to our membership, will clear up this confusion.

ADC (Aid to Dependent Children) is going up about 10% a year due to the fact that the state mental hospitals have turned out about 5,000 patients a year to be placed on welfare and Medicaid at the county level. Also, our society requires higher skills and learning needed for jobs as our society improves. Another reason for this increase is that the domestic family structure has greatly deteriorated in the last few years. This should come as no great news because we realize that there are a number of bad family circles. Free love, fewer marriages have added to an increase in the ADC rate. Some adoption agencies have gone out of business. There are fewer desirable adoptable families remaining.

Continuing with the ADC discussion, there was comment about examinations for those under 21 years of age, which will be probably part of the program. It was estimated that this would cost from 90-to 100-million dollars more—not very possible. In May 1973 the Welfare Department hopes that they may ask for a gross lay screening—"Is the child sick or well?"—then referrals will be made for care as needed.

The question was put to Mr. Stanton about the Welfare Department and their policy on abortions, and he stated as follows, "They will not push abortions, but will pay for abortions."

We were also reminded by the Welfare Department heads that it is impossible to get off the welfare rolls (unless the welfare recipient requests it). It is hoped the needs schedule will be reduced. We were informed that there is a lot of false information concerning the size of welfare checks. The maximum a mother with one child can receive is \$115.00 per month; and for each additional child not more than one dollar, per day, per month, is payable.

We met with several members of the State Medical this year, some of them being ophthalmologists who appeared before the commission. They wish to have a



hearing on why Medicare fee allowances were changed from 1972 to 1973. We listened diligently and tried to help them out and steer them in the best manner that we knew how. I would like to quote to you part of a letter from one of the doctors who met with the commission. It is as follows:

"Your time is not wasted. I got a fine, long, detailed phone call from one of the members of your commission, Dr. Trachtenberg, this week before my appeal and his advice was outstanding. Peer review is time consuming and humbling but we must do it. Your enthusiasm for hearing our problems is surely rewarding. The Bulletin and the Journal should carry more news items from your deliberations so that all members of the profession can benefit from your experience. Specialty groups must pass the word around. Their response (Blue insurance) is to find fault with the doctor's work or to reel off several pages of doubletalk."

The commission hopes that we can have a realistic approval to the PSRO program, and the commission would like to suggest that recent development of PSRO programs for non-government patients be started to gain experiences for the government-type of patients which will come at a later date.

In May of 1973, the Honorable Governor Otis R. Bowen, M.D., named Dr. Jack B. Hardigg of Indianapolis to the new post of Medical Director of Indiana, Department of Correction. The commission has worked for many years to have a medical officer in the department of corrections, and we are especially proud of this achievement.

The staff of ISMA and the CHAM-PUS office have been always helpful and successful in completing our reports and meeting arrangements.

JEROME E. HOLMAN, JR. M.D.,  
*Chairman*

ROBERT E. ARENDELL, M.D.

CHARLES L. McKEEN, M.D.

FRANCIS H. GOOTEE, M.D.

FRED D. HOUSTON, M.D.

O. LYNN WEBB, M.D.

GEORGE E. BRANAM, M.D.

LOWELL R. STEPHENS, M.D.

LEE H. TRACHTENBERG, M.D.

GEORGE A. TEABOLDT, JR., M.D.

MICHAEL J.

MASTRANGELO, M.D.

PAGE E. SPRAY, M.D.

GLEN V. RYAN, M.D.

CHARLES R. ALVEY, M.D.

MRS. JOHN STANLEY

## Interprofessional Relations

### HOUSE ACTION: Ordered filed.

**Recommends approval by the House of Delegates for Joint Practice Committee to become a permanent committee. Recommendation referred to Board of Trustees.**

The Commission first met on January 7, 1973. It was decided that the most pressing order of business was the feasibility of a joint practice commission with the Nurses Association. This had been recommended by the AMA, and Dr. Gabriel Rosenberg reported, following a meeting at Chicago, at which time this was discussed in detail.

After considering Dr. Rosenberg's report and committee discussion, it was felt that the Indiana State Medical Association should make overtures to the Indiana State Nurses Association and explore the feasibility of forming a joint practice committee. This was based on the fact that it was felt that nurses should be encouraged to develop further capabilities in delivering primary health care, in that their preliminary training qualified for this. They had set standards for developing nurses, which could be used as a basis for expansion. Such a committee would give the medical profession considerable control over people who are going to be involved in the primary delivery of medical care as a physician's assistant.

On Sunday, April 8, 1973, the Commission met again along with representatives from the Indiana State Nursing Association. The decision was made to form a joint practice commission in Indiana, consisting of 16 members with equal representation from the Indiana State Medical Association and the Indiana State Nurses Association. It was recommended that this commission be established to survey the entire relationship between physicians and nurses, not only in areas of developing physician's assistants, but in the areas of education, legislation, etc.

Following this, a third meeting was held. At that time, the Committee recommendations were made to Dr. Gosman for the membership of this committee. These recommendations were made to cover the various areas of the various interests of the state, and eight members were suggested to fill this commission. Dr. Gosman, the president, was to have the final decision as to these selections. The Commission was to operate as an ad hoc committee for the time being, in

that it would require approval of the House of Delegates to become a permanent Commission.

The Interprofessional Relations Committee felt that, following the establishment of this committee, the Interprofessional Relations Committee should go into other areas concerning the relationship of medical staffs to administration in hospitals, legislation; and these meetings are planned for the future.

WARREN COGGESHALL, M.D.,  
*Chairman*

ALBERT S. RITZ, M.D.

JACK L. SHANKLIN, M.D.

IGNACIO B. CASTRO, M.D.

GERALD BOWEN, M.D.

RICHARD L. VEACH, M.D.

MARK E. SMITH, M.D.

CLYDE G. CULBERTSON, M.D.

AMBROSE PRICE, M.D.

PAUL E. LUDWIG, M.D.

MITCHELL E. GOLDENBURG, M.D.

J. DEAN GIFFORD, M.D.

MARVIN PRIDDY, M.D.

WILLIAM J. STOGDILL, M.D.

FRED DIERDORF, M.D.

RICHARD W. HOLDEMAN, M.D.

MRS. OTIS BOWEN

## Legislation

### HOUSE ACTION: Adopted.

**Referred to Board of Trustees for information.**

The Commission on Legislation under the chairmanship of Donald E. Wood, M.D., had a very successful year in the state legislature. A full and complete report of the Commission on Legislation's activities during the 1973 session of the Indiana General Assembly was distributed to every ISMA member in June of 1973. This report was prepared by Mike McDermott, the Legislative Assistant for the Indiana State Medical Association. Mike joined our staff on January 8, 1973, the opening day of the 1973 Legislative Session, and worked closely with the commission on all legislative matters.

In addition to meetings held between legislative sessions, the Commission on Legislation met regularly during the months of January through April of 1973 to discuss and review bills pending before the General Assembly. These meetings were held approximately every three or four weeks. The meetings during the month of January were devoted to screening the total of 1,416 bills which had been introduced to determine which bills the Commission would support, op-



pose, or take for information only. The meetings during the remainder of the legislative session were used to review the progress of the bills which were of interest to the Commission. In all, 104 health related bills were monitored by the Commission. Of these 15 bills were actively supported, 15 were actively opposed, and the remaining 74 were taken for information.

A bill status system was developed in an effort to keep members of the Commission and also county medical societies updated on the progress of each individual bill through the legislative system. Information on specific bills of major importance to the ISMA was also sent to county medical societies and to individual physicians throughout the state. These physicians were then encouraged to contact their representatives in the state legislature.

The Commission has also held several meetings since the close of the 1973 session for the purpose of preparing a legislative program which will be presented to the House of Delegates and which will contain bills that the ISMA intends to have introduced for the 1974 session of the legislature. The major piece of legislation which will be presented by ISMA is the new Medical Practice Act.

The interest and enthusiasm of the members of the Commission was evident in their attendance at the many meetings we held. As chairman, I would like to express my thanks for the hard work and cooperation of the members of our Commission as well as the cooperation and interest shown by the legislative representatives in the various county medical societies.

- DONALD E. WOOD, M.D.  
Chairman  
DANIEL C. TWEEDALL, M.D.  
ROBERT ROSE, M.D.  
IVAN A. CLARK, M.D.  
WILLIAM BANNON, M.D.  
JOHN A. DAVIS, M.D.  
JOHN PANTZER, M.D.  
RICHARD L. REEDY, M.D.  
MAX N. HOFFMAN, M.D.  
A. P. BONAVENTURA, M.D.  
RICHARD L. GLENDENING, M.D.  
JERRY L. STUCKY, M.D.  
HARRY STOLLER, M.D.  
JAMES KIRTLEY, M.D.  
DONALD TAYLOR, M.D.  
DeWAYNE HULL, M.D.  
JOE BLACK, M.D.  
JOSEPH McPIKE, M.D.  
LEONARD W. NEAL, M.D.

MRS. G. BEACH GATTMAN  
OTIS R. BOWEN, M.D.  
(Governor-Honorary)

Medical Economics  
and Insurance

HOUSE ACTION: Ordered filed.

The Commission on Medical Economics and Insurance held meetings November 12, 1972, March 4, 1973, and May 6, 1973, and met in joint session with the Commission on Public Information.

The primary objectives of the Commission during the past year were:

- (1) Monitoring the current ISMA Group Insurance Programs;
- (2) Attempting to finalize arrangements for inclusion in the ISMA Group Insurance Program of:
  - (a) Tax Deductible, Overhead Expense Insurance
  - (b) High Limit Major Medical Coverage;
- (3) Attempt to secure a satisfactory Group Medical Liability Coverage.

During the past year the Commission on Medical Economics and Insurance was not charged with any activities involving problems with Blue Shield. As a result, all such inquiries and problems were referred to ISMA officers, ISMA trustees or Blue Shield Board members. This explanation will perhaps answer some of the ISMA members' questions and criticisms regarding our lack of activity in this area.

Currently, the following Group Insurance Programs are in effect for ISMA members. These programs enjoy good participation and have had a good actuarial experience.

I—Group Life Insurance — This program provides up to \$50,000 limits for individuals and professional corporations. A spouse and certain children can be included for limited amounts at small additional premiums. Conversion privileges are available. In addition, for those members under the age of 55 carrying the Group Life Policy, permanent, cash value insurance is available in an equal amount. Payments for deceased members passed \$50,000 as of mid-July.

II—Disability Income Replacement Insurance — is available and provides up to \$1500/month.

Programs expected to be available in late 1973—

I—Overhead Expense Insurance — This would be a tax deductible program available in amounts up to \$3500

maximum for members under 60 years of age. This pays 100% of office expenses for 18 months (based on actual office expenses). If death occurs prior to that time, a 3-month benefit is available, if the insured is drawing benefits. A 15 or 30-day deductible period is provided.

II—High Limit, Major Medical Insurance — with a \$250,000 life time maximum.

III—Disability Insurance for Interns and Residents

The Commission has under serious consideration two approaches for a Group Medical Liability Program. Each has advantages and disadvantages. All require a high percentage of participation of members with a built-in review mechanism by the ISMA. It goes without saying that no insurers are anxious to write this type of program without specific controls. At the direction of the Board of Trustees, further studies are being made on feasibility.

In response to a request from the Reference Committee at the 1972 Convention, the Commission approved and submitted to the ISMA Board of Trustees three forms for the use of ISMA members who desire to use "A Statement of Understanding." These forms were approved by the Board of Trustees:

PATIENT-PHYSICIAN AGREEMENT  
RESPONSIBILITY FOR FEES

I, the undersigned, recognizing that the medical insurance coverage I possess may not completely cover the fee(s) for professional service(s) rendered to me. I hereby agree that I am responsible for said fee(s).

I authorize my physician to give notice to my medical insurance carrier(s) of this agreement.

I am aware that I may make inquiry of my physician relative to fee(s) prior to any professional service(s) required and rendered or at anytime thereafter.

Dated at \_\_\_\_\_

this \_\_\_\_\_ day of \_\_\_\_\_ 19\_\_\_\_

Signed: \_\_\_\_\_

NAME OF PATIENT  
ADDRESS

WITNESS



STATEMENT OF UNDERSTANDING

I agree that the determination of professional medical and/or surgical services to be rendered by my doctor and the fees to compensate him for these services are matters concerning my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for his services, notwithstanding any contract I may have with an insurance company, my employer or my union. Neither my doctor nor I will permit an insurance company, my employer or my union to determine what medical services I need or what fees the doctor should receive in return for these services. Any agreement that either of us may have with an insurance company, my employer or my union shall not affect our doctor-patient relationship and the decisions relating to medical care and fees. Neither my doctor nor I, as his patient, am in any way bound by any contract the other may have with an insurance company, my employer or my union.

Patient

Physician

Witness

JOHN DOE, M.D.  
110 Doctor's Street  
Anywhere, Indiana

Charges estimated in advance of surgery, obstetrics, etc.

OPERATION <sup>1</sup>	\$
ASSISTANT <sup>2</sup>	\$
ANESTHESIA	\$

- 1. Includes normal care and post-operative care. It should be understood this estimate is for normal, uncomplicated service. In the course of care, should complications require additional treatment, the total fee may be more than estimated.
- 2. The surgical assistant will bill the patient for his fee. When the referring physician acts as the assistant, he will bill the patient for his services.

If additional medical care is required, the physician rendering this care will

bill the patient for his services.

The service and payment therefor is a contract between you and I as your physician. I hold you responsible for full payment of all charges regardless of any amount that may be paid by your insurance plan.

I acknowledge receipt of a copy of this form and agree to the terms as set forth.

Signature

The Commission on Medical Economics and Insurance considered the matter of Workman's Compensation Insurance. It is the feeling of the Commission that this matter can best be handled on an individual basis and included with the member's office insurance. The Commission would remind all members that they should check their office insurance program to be sure that Workman's Compensation is included in their office insurance. The insurance, reasonable in cost, is almost mandatory for the physician.

Meeting with the Commission on Public Information, the Commission jointly discussed the possibility of preparing an easily understood pamphlet on Insurance coverage and responsibility for completion of insurance forms, to be made available to ISMA members (similar to Medicaid and Medicare Folders) for use in their offices. This is to be studied further.

The Commission approved the following statement on "Coordination of benefits" and referred this statement to the ISMA Board of Trustees, which adopted the statement:

"Realizing the inequities, sometimes resultant from the coordination of benefits system employed by the group health insurance carriers of Indiana, and also realizing the impact of that system on helping to control the rising cost of health insurance, and remembering the abuses of its predecessor program, the Commission on Medical Economics and Insurance recommends no action be taken at this time to supplant the coordination of a benefits system in payment of group health insurance claims. The Commission also hopes that insurers and employers will achieve better coordination of group policies offered so that such inequities are prevented in the future."

It is understood that in cases of co-

ordination of benefits, the premiums are lower.

- KENNETH O. NEUMANN, M.D.,  
Chairman
- THOMAS J. CONWAY, M.D.
- PAUL M. INLOW, M.D.
- LEO R. NONTE, M.D.
- ROGER F. ROBISON, M.D.
- EDWARD J. PLOETNER, M.D.
- FREDERICK EVANS, M.D.
- LARRY G. COLE, M.D.
- R. JAMES BILLS, M.D.
- JOHN L. FRAZIER, M.D.
- ROBERT C. STONE, M.D.
- WALLACE S. TIRMAN, M.D.
- JACK W. HANNAH, M.D.
- JOEL W. SALON, M.D.
- R. ADRIAN LANNING, M.D.
- MRS. MALCOLM SCAMAHORN

Medical Education and Licensure  
HOUSE ACTION: Ordered filed.

The commission met on December 17, 1972, and March 4, June 10, and September 9, 1973. In addition to considering matters of regular business, some referred by the House of Delegates, the commission also considered business referred from the Board of Trustees and continued with some activities that were carried over from 1972.

The major work of the commission included: (1) ISMA-Student-Faculty Retreat (2) Accreditation of continuing medical education programs (3) ISMA-CME Awards (4) Medical Practice Act (5) Indiana University School of Medicine (6) Preceptor Program (7) House Staff (8) Legislative activities (9) Participation of the commission in planning an educational program for the annual meeting.

1. **ISMA-Student-Faculty Retreat.** The commission helped plan the fourth annual Retreat held in Nashville on April 7 and 8. Two commission members served on the planning committee and three members participated as discussion leaders for three of the four workshops. The commission also was well represented at the Retreat and felt it was an excellent experience for all participants. The full report of the Retreat is presented elsewhere.

2. **Accreditation of Continuing Medical Education Programs.** The commission through its Subcommittee on Accreditation has developed the mechanism for an accreditation system for local intrastate continuing medical education programs—not approved by a national accrediting body. This has been approved by the AMA and will be in conjunction



with the AMA Physician's Recognition Award. All institutions and organizations in the state have been polled regarding their interest in accreditation. Forty have responded and have received the questionnaire. Site visits will be arranged for eligible programs

The commission also plans to award certificates of accreditation to those institutions and organizations as they qualify.

The ISMA Board of Trustees approved the commission's request to authorize the commission to charge institutions and organizations a fee for continuing medical education accreditation surveys and for the clerical work associated with the accreditation procedure.

**3. ISMA-CME Awards.** The AMA has approved the ISMA plan of awarding a special seal to be attached to the AMA-PRA certificate for Indiana physicians completing the AMA-CME requirements. The commission through its subcommittee has requested a list of Indiana physicians qualifying for the AMA-PRA since 1970 and who are eligible for the ISMA award so that they may receive their awards at the annual meeting in October 1973.

The AMA has agreed to review the CME reports of the Indiana physicians, verify their figures, and determine their eligibility for the awards and will make this information available to ISMA.

The commission also plans to award certificates of accreditation to those institutions and organizations as they qualify.

The commission through its subcommittee is requesting that the Board of Trustees and the House of Delegates consider the employment of a director and necessary staff, to head up an office at ISMA headquarters for continuing medical education. (Refer to Resolution No. 5.)

The commission has also recommended a resolution be prepared and submitted to the House of Delegates for the purpose of revising the ISMA Constitution and Bylaws to provide for a standing Committee on Continuing Medical Education to handle the business of CME accreditation and the CME awards. (Refer to Resolution No. 6.)

**4. Medical Practice Act.** Members of the commission have continued the development of the proposed Medical Practice Act, as mandated by the 1972 House of Delegates. There have been several meetings with nurses, optom-

etrists, pharmacists, nurse-anesthetists, anesthesiologists, podiatrists and the physician assistants representing their organizations for their understanding and assistance in the preparation of an act which is satisfactory to all. Following the third meeting, the Act was totally rewritten in legal form which included the necessary changes resulting from these meetings.

The proposed act was again taken to the Indiana State Board of Medical Registration and Examination at their meeting for their review and recommendations. Also attending were representatives from the Indiana Osteopathic Association. The proposed act has again been rewritten. It will be reviewed again by the commission and the other interested organizations and finally the State Board. At the time of writing this report it is the commission's plan to have the proposed act completed for study and action by the ISMA House of Delegates at its 1973 annual meeting with the hope of presenting it to the 1974 legislature.

**5. Indiana University School of Medicine.** At each meeting of the commission a report was made by one of the deans on the progress of the I.U. School of Medicine and its statewide system. Excellent liaison between the commission and the school of medicine has been maintained. The commission has been disappointed, however, at the lack of student participation on the commission. As in the past, the commission wishes to commend the Indiana University School of Medicine for its outstanding program in Indiana and pledges its continued support in all phases of medical education.

The commission viewed an excellent movie produced by the I.U. School of Medicine entitled "Medical Exodus—Diagnosis and Treatment" and recommended it be shown at the annual meeting with a discussion period following the movie, with the regional center directors to serve as the panel.

**6. Preceptor Program.** The commission was advised that the number of physicians willing to serve as preceptors had increased from 40 to about 150, and approximately 60 students had signed for the program.

**7. House Staff Membership.** It was suggested, in order to get more active involvement in ISMA, each county medical society identify with house staff, get acquainted and invite them to join county societies as full members with the right to hold office and have ISMA of-

fer full membership at a reduced fee, allowing full voting privileges. It was suggested that, for state residents, membership be in the county of their origin and, for out-of-state house staff, membership be in the county where they are training. (Refer to Resolution No. 7.)

**8. Legislative Activities.** The commission studied several bills of the legislature relating to medical education and licensure and made recommendations.

**9. Annual Meeting of ISMA.** The commission discussed the desire to assume some responsibility for the educational content of the annual meetings of the ISMA and recommend that in the future the commission have at least one joint meeting annually with the Commission on Convention Arrangements to help plan the educational activities for the conventions. (Refer to Resolution No. 8.)

The chairman wishes to thank Mrs. Willis Stogsdill, representative from the ISMA Woman's Auxiliary, and the members of the commission who contributed much support during the year. A special thanks to Eugene Gillum, M.D., chairman of the Subcommittee on Accreditation (CME) and to members of the subcommittee. Without their conscientious work, the continuing medical education program could not have reached this stage of development.

Our thanks also to the ISMA staff—to Mr. Waggener and to Mr. Bush for their help and advice, to Mr. McDermott, and especially to Mrs. Cary—all of whom worked closely with the commission in lending their assistance.

FRANKLIN A. BRYAN, M.D.,  
*Chairman*

GILBERT HIMEBAUGH, M.D.  
BETTY DUKES, M.D.  
GEORGE G. MORRISON, JR., M.D.  
STANLEY FRODERMAN, M.D.  
DAVID ELLIS, M.D.  
DONALD M. SCHLEGEL, M.D.  
ROSS L. EGGER, M.D.  
SAMUEL C. MILLIS, M.D.  
NICHOLAS L. POLITE, M.D.  
SHOKRI RADPOUR, M.D.  
THOMAS A. ELLIOTT, M.D.  
PETER J. PILECKI, M.D.  
LESLIE BAKER, M.D.  
LINDLEY WAGNER, M.D.  
GLENN W. IRWIN, JR., M.D.  
STEVEN C. BEERING, M.D.  
MERRITT O. ALCORN, M.D.  
STEVEN D. BERKSHIRE  
MRS. WILLIS STOGSDILL



**HOUSE ACTION: Adopted with the following stipulations:**

Specifically page 2, lines 10 through 13 and lines 31 through 36; page 4, line 22 through 26; page 5, lines 14 through 16; and page 7, lines 21 through 24, be studied by the Board of Trustees in concert with legal counsel and involved commissions with possible restructuring of these sections, with the Board of Trustees authorized to final approval or disapproval before a bill is introduced in the legislature.

(Doctor Scamahorn asked the House to support at least that portion of the Act starting on page 8 which has to do with minimum requirements, foreign medical graduates, guidelines, licenses with examination, temporary permits, midwives, etc., and asked also that ISMA support the licensing board in getting revocation, suspension, and probation in the law, which is sorely needed. The Chair interpreted this as already covered, but said if the House wished, it would be approved as a motion. This was seconded and carried.)

(Copies of Draft 7 are available at the Headquarters office.)

## Public Health

**HOUSE ACTION: Ordered filed.**

The 13-member Commission on Public Health held three meetings. Eight of the members attended at least one meeting.

A number of subjects were dealt with and actions taken, as follows:

1. *Amphetamine Survey.* The Board of Trustees requested a year ago that the Commission on Public Health survey the state to see how many county medical societies have implemented the provisions of Resolution 71-5. This resolution suggested the membership discontinue the use of amphetamines, except for a certain condition such as narcolepsy and the hyperactive child. To conduct this survey, the commission asked field representatives to canvass the county medical societies in the regular conduct of their rounds and to ask:

- A. Has your society followed the recommendations of Resolution 71-5?
- B. If so, do members of your county medical society still comply with the moratorium?

Response to this survey was received in June as follows:

Thirty-five of eighty county societies reported. Fourteen of these thirty-five cooperated with the resolution.

2. *Recommendations of the Reference Committee that the Commission on Public Health include all drugs in its next report, not just marijuana.* The Commission on Public Health felt there was misunderstanding about this point. Our report a year ago dealt only with marijuana because this was the specific subject we were asked to write about to the President's Commission on Marijuana and Drug Abuse. They reported only on marijuana at the end of their first year. The second half of their assignment, Drug Abuse, was the subject of the second report at the end of the second year. The Indiana State Medical Association Commission on Public Health was not asked by them for its opinion for this second report. The members of the ISMA Commission on Public Health did not feel competent to make recommendations on all drugs as recommended by the Reference Committee, and we felt any such effort on our part would not be useful in a field well covered already by specialists. We were not able to comply, therefore, with this suggestion.

3. *Position on Small Pox Immunization.* The Commission on Public Health was asked by the Reference Committee for its position on small pox immunization. The commission unanimously supports the statement which it made through one of its members, A. C. Offutt, M.D., to the Board of Trustees one year ago. Essentially, that statement says the individual physician should immunize or not, as he judges best, consistent with good medical practice.

4. *Immunizations in General.* Discussion on measles and other immunizations was held. Concern was expressed about the percentage of protected children in a community falling below a critical level, permitting epidemics (for example, of measles) to occur. Many large cities in Indiana have free clinics for immunizations, but many communities do not. It was decided that the position of the commission should be to continue to emphasize the importance of all immunizations.

5. *Junk Foods Sold in School Cafeterias.* In response to a letter from a citizen in Monroe County complaining to the local county medical society about candy and other junk foods for sale in the school cafeteria, the commission wrote a letter affirming our state policy and that of the American Medical Association as against such sales in school cafeterias.

6. *National Ambulatory Care Survey of the National Center for Health Care Statistics.* This survey is nationwide and concerns all activities of all physicians in

their care of ambulatory patients. The commission endorsed the survey unanimously and recommends that physicians cooperate with it.

7. *Venereal Disease.* Again, as has occurred annually, discussion was held on the subject of special publicity and drives by the State Medical Association to fight V.D. The considered conclusion of the commission, as before, was that enough publicity already exists, and it would not be helpful for our commission to make a special effort here. Local M.D.s and school officials are handling the subject satisfactorily with the plentiful materials which already exist and which are available through the Indiana State Board of Health.

8. *T.B. Testing.* At our meeting on March 18 the commission considered the request of the Board of Trustees that we recommend standards for pre-school tuberculin testing, whether multiple puncture or Mantoux be used. No background information was given us at that time, and the six members present voted unanimously for Mantoux testing with the new stabilized solution of PPD(t).

Before our June meeting we received a letter from Dr. Roland Miller of Lafayette on Tine versus Mantoux testing, and we invited him to come to that meeting. A representative of the State Board of Health was invited too but was unable to attend. Dr. Miller reviewed the feelings of the Indiana Academy of Pediatrics, the law, certain information on the Tine test and suggested that the State Board of Health directive requiring the Mantoux test was restrictive of medical decisions. Dr. A. C. Offutt felt the purpose of the law was to screen, not diagnose the pre-school children. The commission agreed that the Mantoux test was the standard diagnostic test. Finally, the commission made the following recommendation to the Indiana State Board of Trustees: That the State Board of Health be requested to amend its present regulation HT6R, requiring Mantoux testing of pre-school children. The amendment should permit any physician holding an unlimited license to practice medicine and surgery in Indiana to choose that intradermal test which, in the exercise of prudent medical judgment, will satisfy the amendment to the 1967 act. The commission then thought that the above recommendations called naturally for another, to the effect that the State Board of Health initiate a program of professional education in intradermal skin testing, including management of positive reactors.

9. *Regionalization of Health Depart-*



ments. Throughout the year, the commission has inquired and received reports at each meeting on the status of the plan initiated a year ago on the above subject. The plan is in process of consideration by involved groups. Thorough documentation and supportive data is necessary before any approach is made for legislative action.

JAMES JOHNSON, M.D.,

*Chairman*

ARNOLD BROCKMOLE, M.D.

EDGAR CANTWELL, M.D.

GORDON GUTMAN, M.D.

WILLIAM B. SIGMUND, M.D.

FRANCIS B. WARRICK, M.D.

BYRON L. STEGER, M.D.

BRUCE A. WORK, M.D.

HERSCHEL BORNSTEIN, M.D.

WILLIAM K. NEWCOMB, M.D.

WARREN NICCUM, M.D.

RAYMOND E. NELSON, M.D.

ANDREW C. OFFUTT, M.D.

JAMES HAWK, M.D.

HUBERT GOODMAN, M.D.

NOEL L. NEIFERT, M.D.

MRS. EDESEL REED

## Public Information

### HOUSE ACTION: Ordered filed.

The commission met four times during the year to consider the business of the commission.

Plans were completed to utilize a detailed but simplified questionnaire for members of the Association to learn more about their activities. It was the plan of the commission to mail this form with the dues requests and then compile the data on the cards for utilization by the State Medical Association in its various activities with the profession and the public. At the time of writing this report, full approval of the utilization of the form had not yet been given by the Board of Trustees of the Association.

Also, during the year "The Physician's Liability in Patient Care" was completed and was published in the June issue of THE JOURNAL of ISMA with a special feature cover announcement as to the value of this booklet as a ready desk reference for ISMA members.

Tel-Med came into operation during the year and, through the Commission on Public Information, various forms of publicity were given this new health information service, resulting in thousands of telephone calls from throughout the central Indiana area. The commission feels that the program is an extremely valuable one in terms of public relations and reflects the desires of a number of

other physician-members of the Association to extend the program throughout Indiana.

During the year the commission initiated circulation of the waiting room bulletin, question-and-answer type poster. Efforts are being made to encourage more participation in the utilization of this bulletin, which emphasizes in brief question-and-answer style health information, socio-medical-economic facts and medical organization philosophy and policy.

The commission also made selections in its annual journalism awards and its Physician Community Service Award of the Year. These awards annually attract more media participation and more physician interest.

The commission also gave serious consideration to the development of a special program which will utilize lay speakers representing the Association to lay organizations throughout the state. It was pointed out that such efforts by other organizations and corporations had proved effective and the commission will submit a format for the program and a budget to the Board of Trustees of the Association and to the House of Delegates with the hope that monies can be found to place this specialized speakers' bureau in effect during 1974. The estimated cost of such a bureau would run somewhere between \$15,000-\$20,000.

It was felt that the wide range of publicity received from local news media on such visitations and a total effect of intelligent and factual reports to people through the medium of their local community meetings should, over a period of time, have extraordinary effects on individual understanding of many of the positions which physicians take in politics and on socioeconomic matters.

One of the major problems during the year was the television show which was aired by NBC and which contained false facts relative to medical care costs. A letter which was written by Dr. Ernest Howard, AMA executive, to the NBC president, Mr. Julian Goodman, contained an abundance of facts which rebutted the erroneous statements and which could be utilized in the new speakers' bureau program. The commission agrees that it is imperative that this type of information be more widely disseminated. An effective professional speakers' bureau could do much to dispel such blatantly incorrect statements.

The commission monitored the distribution of two leaflets—one entitled "Medicare Misconceptions" and the other "As a Medicaid Patient." They made

known the fact that over 150,000 of these two leaflets were distributed to doctors throughout Indiana. The leaflets were, in essence, an effort to tell the patient the extent and limitations in both the Medicare and Medicaid programs. Physicians utilizing them found them worthwhile.

As an outgrowth of this distribution, the commission turned its thoughts to the development of a similar leaflet on health insurance problems which could be distributed to the lay public for their information and their additional understanding of the insurance industry and the physician's role in the total picture. Consideration is also being given to the development of a professional publication for members of the state society to provide them with more substantial information upon varying insurance programs.

Another new concept involving more direct contact with the media was initiated during the year. It will be the commission's endeavor over the next few months to develop a system whereby material channeled through the ISMA office can, in turn, be channeled to physicians who are close to editors and publishers and other high-level individuals in the media industry throughout Indiana. The system has worked effectively in other areas, especially with the Legislative Commission. Efforts are now being made to gather information on physicians and editors in order to effectively institute the procedure.

The commission also reviewed a special Blue Cross—Blue Shield venereal disease leaflet and made recommendations and suggestions concerning the dissemination of the material throughout the state.

DAVID G. CRANE, M.D.,

*Chairman*

WILLIAM B. CHALLMAN, M.D.

THOMAS O. MIDDLETON, M.D.

LOUIS H. BLESSINGER, M.D.

KENNETH D. SCHNEIDER, M.D.

RICHARD S. BLOOMER, M.D.

HARRY T. HENSLEY, M.D.

THOMAS A. HANNA, M.D.

PAUL BURNS, M.D.

KENNETH J. AHLER, M.D.

JOHN A. FORCHETTI, M.D.

EUGENE T. KARNAFEL, M.D.

FRED DAHLING, M.D.

BARBARA BACKER, M.D.

HARRY G. BECKER, M.D.

VICTOR JOHNSON, M.D.

ROBERT W. HARGER, M.D.

MRS. STANLEY CHERNISH



## Special Activities

**HOUSE ACTION:** Amended report ordered filed.

The Commission on Special Activities met on December 10, 1972, February 18, April 1, and May 6, 1973. The Commission's Subcommittee on Rural Health, chaired by Richard D. Hawkins, M.D., met on February 18, April 1, May 6, and July 8, 1973.

In addition to the Commission's regular members, the meetings of the Commission and of the Subcommittee on Rural Health were attended by several guests and consultants who actively participated in the work of the Commission. These included the ISMA president, James H. Gosman, M.D., William M. Sholty, M.D., Norman Beaver, M.D., Robert Acher, M.D., Mrs. Sarah Ackerson, Mr. Len Bastian, Mr. Marlin Gray, preceptee of Dr. Ellis, and ISMA staff.

The Commission was particularly pleased with the help it received from a number of Indiana University medical students, Robert C. Kaye, Greg Larkin, John C. Johnson and Patrick McAleavey.

The Commission reviewed existing programs that provide financial aid to medical students wishing and/or willing to practice medicine in rural areas. Particular attention was paid to the Rural Kentucky Medical Scholarship Fund as a possible model to be adopted in Indiana. From information gathered, the Commission concluded that forgiveness loans were not popular with medical students and that loan forgiveness plans have not been successful in eleven states. The Commission advised against adoption of such a plan in Indiana.

The Commission reviewed and approved a request from John C. Johnson, a senior medical student and president of Student Council, I.U. School of Medicine, to use the ISMA mailing list to distribute a letter and questionnaire designed to gather data on the physician shortage in Indiana. His subsequently completed study, for which Mr. Johnson was formally commended, was accepted for publication in the *ISMA Journal* and formed the basis for a discussion at a Student-Doctor-Faculty Retreat in Brown County. Mr. John C. Johnson's report and the Retreat generated stimulating ideas which the ISMA Executive Committee referred to the Subcommittee on Rural Health. The Subcommittee has established a temporary Assessment Committee which is preparing a report and recommendations.

Dr. Raymond H. Murray, Director of Regenstrief Institute and Chairman, Department of Community Health Sciences, I.U. School of Medicine, and Mrs. Sarah Ackerson presented the results of a study on the delivery of health care in rural areas. The report, which is being prepared for publication, has provided additional valuable information to the Commission in discussions of health manpower in rural and small town Indiana.

Dr. Richard D. Hawkins attended the AMA Rural Health Conference in Dallas on March 29 and 30, 1973, and reported back the following findings to the Commission:

1. Physicians who are born in rural areas tend to return to rural areas to practice.
2. Physicians have a tendency to practice within 150 miles of where they took their post graduate training.
3. Group practice country-wide has been a tool that has induced a flow of physicians to rural areas.
4. Reasons for doctors either not going to rural areas or leaving rural areas include overwork, lack of continuing education, attitude of wife, lack of cultural opportunities, downgrading of the local M.D. by staffs of medical schools in general, lack of coverage when out of town, lack of a foreseen replacement, and lack of ready consultation.
5. The reasons for practitioners choosing group practice in rural areas include predictable hours, ready consultation and diminution of business management by the individual physician.

The Commission passed the following three suggestions:

1. Whereas, the percentage of family practitioners in the State of Indiana is declining while the percentage of medical specialties is increasing, and  
Whereas, there is an urgent need of more family practitioners, and  
Whereas, more medical students have expressed an interest in family practice training, and  
Whereas, the facilities for training family practitioners are markedly limited owing to a shortage of funds and other resources,  
Now, Therefore Be It Resolved by this Commission on Special Activities of the Indiana State Medical Association that medical educational institutions in the state of Indiana increase their support for family practice residencies and other fam-

ily practice training programs even if this should result in a reduction in current support for training in other specialties.

2. Inasmuch as the family physician has been decreasing in population, yet the current students in medical training evidence a greater interest in family practice over other specialties,

Be It Resolved, that the Council on Medical Education be directed to review the number of available residencies in family practice in relation to other specialties and to consider increasing the number of available residencies in family practice and decreasing those in the specialty fields that are overly represented.

3. Be It Resolved that greater utilization be made of community hospitals, outpatient facilities, and medical practitioners in the support of family practice training programs.

## COMMISSION ON SPECIAL ACTIVITIES

HANUS J. GROSZ, M.D., *Chairman*  
RICHARD B. HOVDA, M.D.  
WILLIAM H. GARNER, JR., M.D.  
JOHN C. LINSON, M.D.  
FRED E. HAGGERTY, M.D.  
JOSE S. CABIGAS, M.D.  
DONALD HUNSBERGER, M.D.  
THOMAS J. STOLZ, M.D.  
DAVID E. ROSS, JR., M.D.  
GEORGE WAGONER, M.D.  
NORMAN BEAVER, M.D.  
THOMAS J. QUILTY, M.D.  
PETER E. GUTIERREZ, M.D.  
ROBERT P. ACHER, M.D.  
DWIGHT W. SCHUSTER, M.D.  
MRS. JAMES GUTHRIE

## SUBCOMMITTEE ON RURAL HEALTH

RICHARD D. HAWKINS, M.D., *Chairman*  
JAMES H. GOSMAN, M.D.  
GEORGE M. ELLIS, M.D.  
ELI GOODMAN, M.D.  
DONALD HUNSBERGER, M.D.  
JOHN C. LINSON, M.D.  
HANUS GROSZ, M.D.  
A. ALAN FISCHER, M.D.  
RAYMOND H. MURRAY, M.D.  
PETER E. GUTIERREZ, M.D.  
ROBERT C. KAYE  
GREG LARKIN



## Voluntary Health Agencies

### HOUSE ACTION: Ordered filed.

The commission met four times during the year to conduct its business relating to Indiana's voluntary health agencies.

Approval was given to the following agencies which submitted comprehensive reports to the commission concerning their programs and activities:

Indiana Division, American Cancer Society, Inc.

The Arthritis Foundation, Indiana Chapter

Indiana Association for Retarded Children

Hemophilia of Indiana, Inc.

Indiana Easter Seal Society for Crippled Children and Adults, Inc.

Indiana Heart Association, Inc.

Indiana Society for the Prevention of Blindness

Kidney Foundation of Indiana

Mental Health Association in Indiana, Inc.

United Cerebral Palsy of Indiana, Inc.

Indiana Lung Association

Tri-State Epilepsy Association, Inc.

Indiana Chapter, National Multiple Sclerosis Society

Indiana Committee to Combat Huntington's Disease

The Commission was saddened by the untimely death of its chairman, Dr. Norman R. Booher, who had directed the activities of the Commission for many years with enthusiasm and innovative ideas. His leadership and dedication to the commission and to organized medicine will be sorely missed.

In keeping with his foresight and energies, the tasks for the commission had been planned to a point by Dr. Booher permitting the commission's business to continue smoothly and without interruption, which in itself speaks for Dr. Booher's commitment.

During the year, members of the Woman's Auxiliary to the Indiana State Medical Association became involved in the commission's activities, naming representatives from each of the 13 ISMA districts and two members at large to complement the organization of the commission.

These representatives were appointed to liaison positions with the agencies along with the commission members and served by attending meetings of the agencies and becoming informed on agency activities.

Mrs. Jack Walker of Yorktown served as chairman of the women's group

through appointment to that position by the president of the Auxiliary, Mrs. Philip L. Smith, Fort Wayne.

Addition of the Auxiliary group in the activities of the commission gave an added dimension to the commission's activities and was received with great appreciation by the agency executives and officers.

Dr. Booher, who had been a member of the American Medical Association Council on Voluntary Health Agencies, advised the commission that the Board of Trustees of the AMA and a follow-up action of the House of Delegates of the AMA had abolished this particular council in the interest of economy. He pointed out he had discussed the entire matter with Dr. Gosman, president of ISMA, who advised him that not only should the ISMA Commission on Voluntary Health Agencies stay active but should strengthen and broaden its activities in Indiana. Dr. Booher commented that a survey of Indiana voluntary agencies revealed that there are roughly 500,000 lay volunteers participating, which offers a tremendous base for providing information on the activities of the commission and organized medicine in Indiana.

The Commission on Convention Arrangements was advised by the Commission on Voluntary Health Agencies on the availability of speakers from the agencies. The agencies, through the commission, had expressed an interest in assisting the convention group in this capacity. The objective of the recommendation was to insure greater economies in the operation of the convention while at the same time maintaining the acquisition of top quality medical speakers for the event.

With the activation of the Tel-Med telephone library and the utilization of some 100 discussions on health topics, the voluntary health agencies expressed interest in participating in the program by offering additional tapes in their particular health areas. The commission feels that a cooperative agreement should be instituted with the approved agencies to add to the library and to further this successful public service.

The commission also printed and distributed the placard identifying agencies that were approved for 1973. Some 10,000 of these placards are distributed annually by the commission and the agencies for the information of the public. The commission feels that this is a worthwhile public service since it does give the citizens of Indiana an opportuni-

ty to know of the many excellent agencies which meet the rather stringent criteria for approval and can help them in directing their personal support, since the backbone of agency operation is voluntarism.

The commission also held during the year its annual meeting with executives, officers and board members of the agencies. Some 75 members of the commission, the Auxiliary, and the agencies were in attendance. The meeting is held to exchange information and ideas on continued cooperation and development of programs between the groups. Suggested participation in Tel-Med was one of the outgrowths of this year's meeting.

At the suggestion of the agencies, the commission this year instituted extending invitations to selected agency representatives to attend regular meetings of the commission and to participate in the deliberations of the commission.

The commission worked in cooperation with the Commission on Public Information in requesting consultation on methods of publicizing the activities of the commission.

The Commission on Public Information recommended that the Commission on Voluntary Health Agencies develop a book styled in the format of the American Medical Association's booklet on national voluntary health agencies, with the distribution of the booklet (which would basically outline the purposes and services of the agencies) coordinated through the Commission on Public Information.

The commission recommends that this be one of the projects for the 1973-1974 Commission on Voluntary Health Agencies.

NORMAN R. BOOHER, M.D.  
*Chairman (Deceased)*

E. DE VERRE GOURIEUX, M.D.

ROBERT H. RANG, M.D.

T. A. NEATHAMER, M.D.

WAYNE CROCKETT, M.D.

DONN R. HUNTER, M.D.

LOWELL W. PAINTER, M.D.

WALFRED A. NELSON, M.D.

WENDELL W. AYRES, M.D.

FRANK J. MCGUE, M.D.

CHARLES RUSHMORE, M.D.

ALVIN T. STONE, M.D.

ROBERT W. BRIGGS, M.D.

*Woman's Auxiliary Liaison Members to Voluntary Health Agencies*  
MRS. JACK WALKER,  
*Chairman*



MRS. RALPH DREYER  
 MRS. A. W. RATCLIFFE  
 MRS. W. R. VAUGHN  
 MRS. JOHN PARIS  
 MRS. MICHAEL FREE  
 MRS. MILTON CALDWELL  
 MRS. JAMES GUTHRIE  
 MRS. H. R. WIREY  
 MRS. CARLSON SPECK  
 MRS. J. J. LIND  
 MRS. A. MAYORGA  
 MRS. EUGENE RIFNER  
 MRS. RONALD KLEOPFER  
 MRS. DAVID D. OAK

## Emergency Medical Services

### HOUSE ACTION: Adopted.

The first meeting of the Commission on Emergency Medical Services was held January 7, 1973. Dr. Cleon Schauwecker was elected vice-chairman and Dr. Howard Williams, secretary. A Bill granting legislative status to paramedical personnel involved in Emergency Medical Care was discussed and was recommended to the Legislative Study Committee for action. The Commission also discussed the Emergency Medical Services Bill of 1973 and its possibilities for passage in the current Legislature.

In the next meeting of the Commission on March 18, 1973, the principal matter for discussion was the fate of the Indiana Emergency Medical Services Act of 1973. It was the Commission's feeling that the bill was being purposely watered down from a comprehensive program of Emergency Care to one involving only ambulance and technician training. The Commission also felt that there was an obvious trend to eliminate medical professionals from any part in planning the bill. As a result of these discussions, it was felt that the Indiana State Medical Association should spearhead an effort by "Health Professionals" to push for a comprehensive program and bill to be prepared for the 1974 Legislative Session. As a result of this discussion the group voted to establish an Indiana Emergency Medical Services Council, composed of health professionals including physician groups, nursing groups and the Hospital Association. Subsequently, letters were sent to representatives of the American College of Surgeons, the Indiana Academy of Family Practice, the American College of Emergency Physicians, the American College of Phy-

sicians, the Indiana State Nurses Association and the Indiana Hospital Association. These groups were invited to send representatives to an initial meeting which was subsequently held Wednesday, May 2, at the offices of the Indiana State Medical Association.

At this meeting, a long discussion of the problems confronting Emergency Medical Services in the state of Indiana was carried out. A committee was formed to establish basic standards of emergency medical care which would then be presented to the Governor as representing what the "Health Professionals" in the State of Indiana deemed necessary for their patients. These standards were very rapidly developed and were subsequently passed upon by the Boards of Directors of the various agencies mentioned above; including the Indiana State Medical Association.

Another meeting of the Emergency Medical Services Council was held at the State Medical Headquarters on May 23, 1973. At that meeting some changes were made in the standards and a very interesting discussion of legislative mechanics was given the group by Dr. William Paynter, the new Commissioner of the Indiana State Board of Health. The entire group was quite happy with the sentiments of cooperation expressed by Dr. Paynter and greatly appreciated his sage advice on how to present this problem to the Legislature and to the Governor.

On May 25, 1973, a group including representatives of Indiana nursing organizations, the Indiana Hospital Association and the Indiana State Medical Association met with Governor Bowen. State Medical was represented by Mr. Waggener, Dr. Suelzer and Dr. Gosman. Governor Bowen expressed his feeling that Emergency Medical Service Legislation was of high priority and pledged the support of his administration for passage of such a Bill in the next legislature. He also granted permission to call a one-day "Governor's Conference on Emergency Medical Services."

Subsequent to the meeting with Governor Bowen, a steering committee was established to plan the conference. At the point of time this report is written, the conference has been scheduled for July 23, 1973. It is to be held in the new Convention Center in downtown Indianapolis, with an anticipated attendance of approximately 500 people. Governor Bowen will give the opening address. The main purpose of the meeting will be to bring together all interested

parties to discuss, revise and draft legislation for the upcoming session. It was felt by all of the "Health Professionals" that many people who to this point have opposed such legislation have done so out of ignorance of its purpose and of the enormity of its restrictions. It was felt that just by getting a large number of these people together to discuss the problem we could dispel many of the problems.

The chairman of the Commission on Emergency Medical Services wishes specifically to thank certain members of the Commission for their regular attendance at meetings and for their support and interest in the projects of the Commission; Drs. Schauwecker, Williams, Gossom, Babb, Farquhar and Graber. The attendance and interest of Mrs. Phillip L. Smith, president of the Woman's Auxiliary to the Indiana State Medical Association is also appreciated.

JOHN G. SUELZER, M.D.  
*Chairman*

RAYMOND W. NICHOLSON, M.D.  
 GEORGE N. LEWIS, M.D.  
 CHARLES B. CARTY, M.D.  
 HENRY SCHIRMER RILEY, M.D.  
 DONN R. GOSSOM, M.D.  
 WILLIAM F. KERRIGAN, M.D.  
 HOWARD WILLIAMS, M.D.  
 DAVID J. DIETZ, M.D.  
 FORREST J. BABB, M.D.  
 WILLIAM NOWLIN, M.D.  
 THOMAS R. SCHERSCHEL, M.D.  
 JOHN S. FARQUHAR, JR., M.D.  
 JAMES D. FINFROCK, M.D.  
 CLEON SCHAUWECKER, M.D.  
 MARTIN J. GRABER, M.D.  
 MRS. PHILIP L. SMITH

## Resolutions

### Resolution No. 73-1

**Subject:** REDECLARATION  
 OF NON-PARTICIPATION POLICY

### HOUSE ACTION: Adopted.

Whereas, The free enterprise, fee-for-service system of medical practice in the United States makes most efficient use of available medical personnel, encourages high quality medical care, and preserves the freedom of patient and doctor; and

Whereas, Government intervention between the practicing physician and the



patient historically removes responsibility from both parties and leads to decrease in quality of medical care; and

Whereas, The provisions of PSRO would sharply interfere with the nature of the doctor-patient relationship and lead to a poorer rather than a better health care standard in this country; now, therefore, be it

Resolved, That the Clark County Medical Society urge the Indiana State Medical Association to notify the Department of Health, Education, and Welfare that its membership will be encouraged to not participate in PSRO-type activities.

### Resolution No. 73-2

**Subject:** REDECLARATION OF NON-PARTICIPATION POLICY

**HOUSE ACTION:** Following Substitute Resolution No. 73 - 2 adopted in lieu of Resolution No. 73 - 2.

Whereas, Advertising by members of the healing arts is unethical and is not in the best interest of the health care consumer, and

Whereas, At present there is nothing in the laws governing the various branches of the healing arts which prevents advertising,

Therefore, Be It Resolved that the Clark County Medical Society recommends that the Indiana State Medical Association take all necessary steps to encourage the formulation and passage of appropriate legislation in the state of Indiana to prevent advertising in the Public media by all members of the healing arts

### Resolution No. 73-3

**Subject:** ESTABLISHMENT OF AN ISMA SECTION ON ALLERGY  
**HOUSE ACTION:** Adopted.

Whereas, There is an extreme shortage of well-trained allergists to care for the allergic patient load in the state of Indiana; and

Whereas, The medical schools in every state surrounding Indiana have departments of allergy and allergy resident training programs and the Indiana University School of Medicine does not; and

Whereas, Establishment of a Section on Allergy in the Indiana State Medical Association would be instrumental in furthering the development of a Department of Allergy at the Indiana Univer-

sity School of Medicine; and

Whereas, Programs can be developed on a postgraduate level to help further the education of doctors already in practice concerning allergies; and

Whereas, The Section on Allergy also could participate in programs at the annual meeting of the Indiana State Medical Association, offering papers of current interest to those practicing general medicine and special programs for those who limit their practice to allergy; and

Whereas, The annual meeting of the Indiana State Allergy Society could be held during the annual meeting of the Indiana State Medical Association, thus increasing attendance and participation in both meetings; therefore, be it

Resolved, That the Indiana State Medical Association establish a Section on Allergy.

### Resolution No. 73-4

**Subject:** SPECIAL REFERENCE COMMITTEE  
**HOUSE ACTION:** Adopted as amended.

Whereas, The Special Reference Committee of the 1972 annual meeting heard extensive, valuable testimony; and

Whereas, This is an opportunity for all members of the Indiana State Medical Association to make their views known to the officers, to the House, and to the Board of Trustees; and

Whereas, The attendance at this Special Reference Committee was extremely large, and enthusiastic; now, therefore, be it

Resolved, That a Special Committee, open to all members of ISMA, be held in conjunction with the annual meeting to provide information not otherwise obtainable by the officers, the Board of Trustees and the House of Delegates.

### Resolution No. 73-5

**Subject:** ADDITIONAL ISMA STAFF MEMBERS  
**HOUSE ACTION:** Adopted. Referred to Board of Trustees for implementation and for monies to do so.

Whereas, The ISMA House of Delegates has approved an ISMA continuing medical education accreditation system and a CME award on the recommendation of the Commission on Medical Education and Licensure; and

Whereas, There is a large amount of additional work required to carry on the system; and

Whereas, The present ISMA staff will be unable to handle the additional work load; now, therefore, be it

Resolved, That the House of Delegates authorize the employment of a director, with necessary staff, to head an office for continuing medical education. (Attached fiscal note)

Fiscal Note—estimated cost per year \$10,000. Salary of director, secretarial work and office equipment.

### Resolution No. 73-7

**Subject:** HOUSE STAFF MEMBERSHIP  
**HOUSE ACTION:** Adopted as amended.

Whereas, The ISMA is encouraging house staff officer participation in the ISMA; and

Whereas, The ISMA needs to develop programs devoted to house staff concern and needs house staff input; now, therefore be it

Resolved, That the house staff be encouraged to join both county society and ISMA at a reduced rate; and be it further

Resolved, That interns, residents, and fellows still in a formal training program be encouraged to join both County Society and the Indiana State Medical Association. Dues for their membership in the Indiana State Medical Association shall be at a reduced rate to be determined by the Board of Trustees; and be it further

Resolved, That the membership be a full membership with all the privileges to vote and hold office.

### Resolution No. 73-8

**Subject:** ANNUAL MEETING EDUCATIONAL PROGRAM  
**HOUSE ACTION:** Adopted.

Whereas, The Commission on Medical Education and Licensure has a definite interest in and responsibility for the educational activities of ISMA; and

Whereas, No formal arrangements have been made for the commission to participate in planning the educational activities of the annual meeting of the ISMA; now, therefore, be it

Resolved, That in the future there be at least one joint meeting annually of the Commission on Medical Education and Licensure with the Commission on Convention Arrangements for the purpose of helping plan the educational activities for the annual ISMA convention.



## Resolution No. 73-9

**Subject:** DRUG ABUSE  
**HOUSE ACTION:** Ordered filed.

Whereas, The rising problem of drug abuse, especially narcotics, is of increasing concern to all Americans and especially to physicians; and

Whereas, The United States government with state and local help has established many programs to combat this problem; and

Whereas, President Nixon expresses our government's leadership in combating the criminal drug trade stating, "Any government whose leaders participate in or protect the activities of those who contribute to our drug problem should know . . . Our goal is unconditional surrender of the merchants of death who traffic in heroin"; and

Whereas, Red China has and is producing, refining, and exporting heroin as a cash crop, estimated to be well over half the world's illegal supply. That this is the official governmental policy of Red China, has been confirmed by our narcotics officials and those of the Republic of China (Taiwan), Great Britain, Holland, and France; and

Whereas, Red China, in addition to other forms of smuggling, uses diplomatic and commercial attaches in other countries to carry out this illicit trade; and

Whereas, The Red Chinese are making arrangements to set up their first liaison office in Washington, D.C., to facilitate relations between the United States and Red China; and

Whereas, As physicians we must oppose any actions detrimental to the health and well being of our patients and oppose any activities which would increase the dangers of greater narcotic traffic; therefore, be it

Resolved, That we, the members of the Tippecanoe County Medical Society, respectfully request President Nixon to specify as one of the conditions for establishing such liaison offices that Red China join with other nations in combating rather than promoting the narcotics traffic; and, be it further

Resolved, That a letter to this effect be sent to President Nixon, Senators Hartke and Bayh, and Representative Earl Landgrebe; and, be it further

Resolved, That a copy of this resolution be sent to the Indiana State Medical Association for its approval.

## Resolution No. 73-10

**Subject:** LEGISLATION TO  
DEFINE THE WORD  
"PHYSICIAN"  
**HOUSE ACTION:** Adopted.

Whereas, Indiana courts have construed the word "physician" to include a person in the practice of chiropractic; and

Whereas, The term "physician" is ordinarily understood by laymen to signify persons who are graduates of schools of medicine or schools of osteopathy; and

Whereas, The application of this term to graduates of schools of chiropractic is misleading as to both the amount and the quality of education of the practitioner; and

Whereas, The validity of the foregoing statements has been recognized by a formal endorsement of the Indiana State Medical Association House of Delegates in annual convention in October 1972; and

Whereas, The staff of the Indiana State Medical Association did subsequently seek to encourage members of the Indiana State Legislature to redefine the legal meaning of the term "physician" through support of appropriate legislation; now, therefore, be it

Resolved, That the Indiana State Medical Association again prepare and seek to have introduced into the General Assembly a bill defining the term "physician" as applying only to persons holding the academic degree of Doctor of Medicine, or Doctor of Osteopathy.

## Resolution No. 73-11

**Subject:** HOUSE OF  
DELEGATES  
MEETING(S)  
**HOUSE ACTION:** Not adopted. Referred to Future Planning Committee.

Whereas, A significant portion of the business conducted during the meeting of the House of Delegates relates to and is important to the design of state legislation;

Whereas, The input to legislative committees has its maximum relative impact in the summer months prior to the convening of Legislature; and

Whereas, The Indiana State Medical Association meets in the fall, making House of Delegates' recommendations incident upon the legislative committees after most of their work is complete;

now, therefore, be it

Resolved, By the House of Delegates of the Indiana State Medical Association that:

1. If one meeting of the House of Delegates is held in any calendar year, that the meeting date will be between the 1st of April and the 15th of May.
2. If two meetings are held, that only one meeting will be accompanied by a scientific session, and that the dates of the meetings be as follows: one between April 1st and May 15th, and the second between October 1st and November 15th.

## Resolution No. 73-12

**Subject:** FISCAL  
RESPONSIBILITY  
**HOUSE ACTION:** Not adopted.

Whereas, Fiscal responsibility is required of all viable organizations; and

Whereas, Evidence of such responsibility should be furnished to the membership of such organizations; now therefore, be it

Resolved, That a full breakdown of monies expended to individual members of the Indiana State Medical Association who act in an official capacity in and for the Association be added to the annual financial report appearing in *The Journal* of the Indiana State Medical Association.

## Resolution No. 73-13

**Subject:** PRESCRIPTION  
LABELING  
**HOUSE ACTION:** Adopted as amended.

Whereas, Accidental poisoning of children and drug overdose by adults of prescription drug items is an all-too-common occurrence in this state; and

Whereas, The treatment of this problem frequently is undertaken at hours when information concerning the exact nature and strength of the drug involved is difficult to obtain either from the pharmacist and/or physician; and

Whereas, This problem is the rightful concern of every physician and pharmacist practicing in this state; now therefore, be it

Resolved, That the Board of Trustees of the Indiana State Medical Association strongly recommend to the governing body of the Indiana Pharmaceutical Association and its membership that a statewide program be initiated to cause the printing of the name, strength, and amount dispensed of the prescription drug



on the label of every prescription filled, unless stated to the contrary in writing by the prescribing physician and refer to the Legislative Commission for necessary legislation.

## **Resolution No. 73-14**

**Subject:** CORRELATION OF  
MEDICAID/  
MEDICARE  
REGULATIONS AND  
PROVIDER  
PAYMENTS  
**HOUSE ACTION:** Adopted as amended.

Whereas, At its July 22 meeting the Commission on Aging adopted the following; now, therefore, be it

Resolved, That this Commission on Aging go on record of accepting the concept of attempting to correlate Medicaid and Medicare for Medicaid patients in all matters of regulation and payment to providers; and be it further

Resolved, That this Commission, along with the assistance of all health providers represented at the July 22 meeting, and any other health providers deemed advisable, join in an effort to help accomplish this procedure, and be it further

Resolved, That this Commission refer this matter to the Board of Trustees and to the House of Delegates for their approval, and be it further

Resolved, That this matter be referred to the ISMA Commission on Legislation for necessary research and introduction in the next session of the Indiana General Assembly with possible referral to the Congress of the United States, and be it further

Resolved, That the Indiana State Medical Association make efforts to establish one simplified method of certification for the entire state of Indiana.

## **Resolution No. 73-15**

**Subject:** PHYSICIAN ADVISORS TO  
THE INDIANA SOCIETY,  
AMERICAN ASSOCIATION  
OF MEDICAL ASSISTANTS  
**HOUSE ACTION:** Adopted.

Whereas, The Constitution of the Indiana Society, American Association of Medical Assistants, now provides that the state physician advisors to the Society shall be the Executive Committee of the Indiana State Medical Association; and

Whereas, Such officers of the Indiana State Medical Association are extremely busy with their own meetings and duties of office; and

Whereas, The Society is concerned by the resulting lack of contact and guidance by the Indiana State Medical Association; therefore, be it

Resolved, That three physician advisors be elected by the Board of Directors of the Indiana Society, American Association of Medical Assistants, for one, two and three-year terms and, as vacancies occur, each advisor be elected for a three-year term; and, be it further

Resolved, That the names of the advisors, as they are elected, be submitted to the Executive Committee of the Indiana State Medical Association for approval.

## **Resolution No. 73-16**

**Subject:** SUPPORT OF INDIANA  
ACADEMY OF FAMILY  
PHYSICIANS IN OBTAIN-  
ING FUNDS, THROUGH  
STATE LEGISLATION,  
FOR DEVELOPMENT OF  
NEW FAMILY PRACTICE  
RESIDENCY POSITIONS  
**HOUSE ACTION:** Adopted as amended.

Whereas, It is estimated that there is a shortage of more than 756 family physicians in Indiana; and

Whereas, 128 students in the Class of 1974 have indicated family practice as their first career choice in medicine; and

Whereas, Only 35 first-year family practice resident positions are available to these students in Indiana (this represents the seven family practice residencies in the state); and

Whereas, Conservative estimates of the Indiana Academy of Family Practice conclude that at least 100 physicians should be entering family practice in Indiana each year for ten years to eliminate the present physician shortage; and

Whereas, It costs from \$25,000 to \$30,000 per year to train each family practice resident, presently being funded by the hospital bed tax, the \$2,000 per year per resident from the State of Indiana, and fees collected in the family practice model units (which usually are operated at a deficit); and

Whereas, Expansion of present programs, or development of future programs, cannot be accomplished without additional funding from the state or other outside sources; and

Whereas, Cost analyses of family practice education programs have revealed that approximately one-third of the cost of resident training is in the form of free care to citizens of Indiana; and

Whereas, The Rural Health Commit-

tee of the Indiana State Medical Association has investigated the situation and feels that state funding of family practice programs is needed sorely; therefore, be it

Resolved, That the Indiana State Medical Association support the endeavors of the Indiana Academy of Family Physicians to obtain state legislation to provide funds for the development of new family practice residency positions in this state (including newly developed positions as of the Fall of 1971), as long as such funds are provided solely for that purpose; and, be it further

Resolved, That the Indiana State Medical Association advise, support and assist the Indiana Academy of Family Physicians in its attempt to gain rural backing of such legislation for communities with and without physicians and, in addition, help in the Academy's lobbying efforts.

## **Resolution No. 73-17**

**Subject:** RETIREMENT MEMBERSHIP  
**HOUSE ACTION:** Adopted as amended.  
**To be voted on at 1974 annual meeting.**

Whereas, Some members in good standing in the ISMA may choose voluntary retirement from the practice of medicine before the age of 70; and

Whereas, Some, and probably most, of these physicians, at the time of voluntary retirement, will have been members of the ISMA for many years; and

Whereas, These voluntarily retired physicians are not financially or medically eligible for remission of dues; and

Whereas, This small segment of physicians would provide a mature and responsible group with freedom to participate actively as members, as committeemen or officers of the society; and

Whereas, At the present time, no membership category or dues structure exists to encompass such early retirement; be it therefore, now

Resolved, That the ISMA shall establish a membership category and dues structure to accommodate such physicians choosing voluntary retirement as noted above; and, be it further

Resolved, That the dues for this new membership category shall not exceed one half of the full membership dues applicable at the time of retirement; and, be it further

Resolved, That this new membership category shall continue to entitle the member to all rights and privileges of membership in the ISMA.



## Resolution No. 73-18

**Subject:** CREATION OF SECTION ON UROLOGY

**HOUSE ACTION:** Adopted.

Be It Resolved, That Chapter 3 of the Bylaws, Section 1, be amended by adding the following, Item O, Item P, Section on Urology and replacing the present Item P as Item Q.

## Resolution No. 73-19

**Subject:** OPPOSING THE QUALITY ASSURANCE PROGRAM FOR MEDICAL CARE IN THE HOSPITAL AS PROPOSED BY THE AMERICAN HOSPITAL ASSOCIATION

**HOUSE ACTION:** Adopted with the recommendation that the Public Information Commission give adequate publicity as to why this program is opposed and so it will not be construed as against good quality of care.

Whereas, The Quality Assurance Program (QAP) of the American Hospital Association is a veiled form of permitting more hospital control of the practicing physician; and

Whereas, QAP permits AHA to investigate the practice of doctors as it so desires; and

Whereas, The QAP will permit peer review, not only by other physicians but also by lay members of the Board of Trustees; and

Whereas, The QAP forces each individual physician to subordinate himself to the judgment of the group instead of using his own judgment as the case requires or his abilities dictate; and

Whereas, The QAP will make it difficult to promote change without prior acceptance by the AHA, thereby virtually denying physicians the opportunity to try new therapeutic and technical advances; and

Whereas, The AHA plans to blame any rise in costs of hospital care on physicians care when actually many other factors of hospital administration contribute a larger measure of the increasing rates with only nominal control of expenditures by physicians; now, therefore, be it

Resolved, The Indiana State Medical Association not only opposes but rejects any form of the Quality Assurance Program of the American Hospital Association.

## Resolution No. 73-20

**Subject:** CONCERNING STATE HIGHWAY COMMISSION

**HOUSE ACTION:** Adopted as amended. Referred to Commission on Emergency Medical Services for their study with the recommendation that consideration be given the suggestion that a physician serve in an advisory capacity on the State Highway Commission.

Whereas, Many organizations have requested medical help in preventing highway accidents; and

Whereas, Physicians have been requested to help rid the highways of the unfit driver; and

WHEREAS, The Indiana State Medical Association members have been asked to assist in setting standards for emergency medical help for the injured driver; now, therefore be it

Resolved, This resolution be referred to the Commission on Emergency Medical Services for their study with the recommendation that consideration be given the suggestion that a physician serve in an advisory capacity on the State Highway Commission.

## Resolution No. 73-21

**Subject:** INVOLVEMENT IN PSRO  
**HOUSE ACTION:** Adopted as amended.

Whereas, Public Law 92-603 calling for establishment of a PSRO mechanism in every state of the nation not later than January 1, 1976;

Whereas, The law makes provision for such organizations to be formed on a trial basis as of January 1, 1974; and

Whereas, The Board of Trustees has gone on record as stating their opposition to this poor law; and

Whereas, The Board of Trustees is of the opinion that this House of Delegates has but two options, one of involvement and one of non-involvement in PSROs; and

Whereas, Resolution No. 1-73 recommends non-involvement in PSROs; and

Whereas, This resolution is presented to provide for an alternative means of peer review and quality control without government control; now, therefore, be it

Resolved, That the Indiana State Medical Association be permitted to establish an independent corporation to accomplish peer review and quality control, such review to be conducted only at the request of the local reviewing

body; and be it further

Resolved, That the Indiana State Medical Association urge the members of Congress and senators of the state of Indiana to repeal the PSRO provisions of PL-92-603.

## Resolution No. 73-22

**Subject:** ESTABLISHMENT OF A FOR-PROFIT CORPORATION

**HOUSE ACTION:** Adopted.

Whereas, The Commission on Medical Economics and Insurance has conducted extensive studies during the past three years on professional liability and other insurance programs; and

Whereas, The Commission feels there would be substantial economies by the establishment of such a corporation; and

Whereas, The Board of Trustees concurs that the Association could, in all probability, develop better insurance programs for the membership; now, therefore, be it

Resolved, That the Indiana State Medical Association through the Board of Trustees be authorized to establish a for-profit corporation.

## Resolution No. 73-23

**Subject:** INCREASE IN DUES  
**HOUSE ACTION:** Adopted as amended.

Whereas, The Board of Trustees of the Indiana State Medical Association heartily endorses the recommendation of the Commission on Public Information to establish a Professional Speakers Bureau for the purpose of carrying Medicine's message to the public of the State of Indiana; and

Whereas, We agree that we should experiment with this type program for a two-year period; and

Whereas, To carry out this program will require additional funds;

Now therefore, be it resolved, That the annual dues of the Association be increased \$10.00 per year for the next two years; and

Be it further resolved, That this activity shall be reviewed at the end of a two-year period to determine if it should be continued or discontinued.



## Resolution No. 73-24

**Subject:** BLUE SHIELD CONDITIONS  
FOR ILEAL BY-PASS SUR-  
GERY COVERAGE

**HOUSE ACTION:** Not adopted.

Whereas, on September 13, 1973, Blue Shield of Indiana informed Doctors Assistants of conditions required to be met prior to reimbursements for Ileal By-Pass Surgery Coverage—Federal Employee Program and thus did state conditions which can be construed to be criteria for the management of morbid obesity; and

Whereas, such action tends to establish the principle of third parties establishing the criteria for medical practice; and

Whereas, the establishment of criteria for medical practice is the responsibility of the medical profession and the application of said criteria the responsibility of the individual physician; and

Whereas, such third party intrusion does compromise the established patient-physician relationship as it exists in the American society; and

Whereas, insurance carriers are specifically prohibited from practicing medicine in the state of Indiana, be it

Resolved, That Blue Shield of Indiana and all third party carriers be admonished by the Indiana State Medical Association from establishing criteria for the performance of any medical or surgical procedure; and be it

Further resolved, that Blue Shield of Indiana be requested to rescind their letter of September 13, 1973, regarding Ileal By-Pass Surgery Coverage—Federal Employee Program.

## New Procedures For Resolutions and Reports

It was moved, seconded and carried that from this time forward, on all commission, committee, and officers' reports requesting some action to be taken by the House of Delegates, it should be submitted in resolution form.

## Tribute To Dr. William R. Clark

DOCTOR SENSENY: "I want at this time to pay homage to Dr. Bill Clark, who has been an alternate and trustee in this organization for the past 11 years. The District is extremely grateful to Bill for his service and wants to express its gratitude and the hope the House will go along with this and it could be reflected in the minutes."

## Letter to President Nixon from California Medical Association Concerning Physicians under Phase IV

**HOUSE ACTION:** Adopted

Mr. President:

This House was advised yesterday by Dr. Malcolm Todd, president-elect of the American Medical Association, that the California Medical Association has forwarded a message to the Board of Trustees of the AMA which reads as follows:

"The California Medical Association urges the American Medical Association to take immediate and appropriate action to counteract discriminatory and inequitable treatment of physicians under Phase IV, coordinating the efforts closely with all state medical associations so that the medical profession can present a strong unified front on this vital issue.

"It is further urged that in its consideration of the alternative of launching legal action, the AMA carefully evaluate the best location in the nation in which to institute a suit.

"The California Medical Association requests that the AMA advise us within the next few days what steps it intends to take. We must respond to the grave concerns expressed by our members now.

"It is understood that the California Medical Association reserves the right to initiate its own action."

Mr. President, on behalf of the Marion County Medical Society delegation, I move that this House take similar action and that it advise the Board of Trustees of the American Medical Association immediately.

## Presidential Resolution

**HOUSE ACTION:** Adopted by acclamation.

Whereas, The ISMA Convention concludes the term of a president and heralds the direction of a new leader; and

Whereas, The 12 months of activity for a president continues to grow in volume with the increasing demands of the membership and the rapid pace of developments in the world of medical practice and medical organization involvement; and

Whereas, Our president this year has given conscientious service through attendance at practically every Commission and Committee meeting and has met with County and District Medical Societies; and

Whereas, He has also met with allied

professional groups and appeared before lay organizations on behalf of medicine, explaining tirelessly the attitudes, viewpoints and programs of the Association; now, therefore, be it

Resolved, That this House of Delegates extend to President James H. Gosman their sincere tribute of thanks for a term of activity of the highest value to the Indiana State Medical Association.

## Resolution of Appreciation

**HOUSE ACTION:** Adopted as amended. Resolution to the hotels, City of Indianapolis and Indiana Convention Exposition Center.

Whereas, The 124th Convention of the Indiana State Medical Association is concluding, and

Whereas, This convention can be considered one of the outstanding ones in the history of ISMA, and

Whereas, A convention of this size, with its concurrent sessions, its multitude of speakers and the business sessions of the official bodies of this organization involves a never-ending amount of attention to detail and planning; and

Whereas, The staff of the ISMA has performed its administrative tasks with dispatch and efficient capability, devoting long hours to the business at hand; now, therefore, be it

Resolved, That this House of Delegates express its thanks to this hard-working and dedicated group for a job well done; and be it further

Resolved, That thanks be extended to the hotels and the City of Indianapolis for the accommodations and hospitality; and be it further resolved, that, in view of the many complaints concerning the Convention Exposition Center, we try to avoid utilizing this facility again.

## Place of Future Annual Conventions

1974—Indianapolis—October 5-10

1975—French Lick—October 18-23

1976—Indianapolis—October 9-14

1977—Indianapolis—(dates to be set by Board of Trustees)

1978—French Lick—October 14-19

## Adjournment

The House of Delegates adjourned, sine die, at 11:30 a.m., Thursday, October 11, 1973.



# Where do you stand on this Legislation? Test Yourself:

Pro    Con

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Maternal and Child Care programs?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Federal funds to expand medical schools?                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Federal aid to medical students?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Expanded nurse training programs?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Expanded physician's assistant programs?                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Restricted experimentation of HMO's?                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | More effective occupational health and safety laws?                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Nation-wide program of community emergency medical services?             |
| <input type="checkbox"/> | <input type="checkbox"/> | <i>Voluntary</i> national health insurance?                              |
| <input type="checkbox"/> | <input type="checkbox"/> | National health insurance plan federalizing all health and medical care? |

If you're for the first nine but against the tenth,

you stand where the AMA stands. We have vigorously supported virtually all recent legislation to provide more and better health care for the public. We have just as vigorously opposed any plan that would infringe on your right to practice the way you choose.

On such vital issues, the AMA is the most effective and influential spokesman that we, the profession, have. Together, we can make it even more effective in representing ourselves, and our views.

**Join us.**

**We can do much more together.**

American Medical Association  
535 N. Dearborn St./Chicago, Ill. 60610





# COMMERCIAL ANNOUNCEMENTS

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**EXCELLENT OFFICE SPACE** available, Professional Building, 6049 E. Washington St., Indianapolis. Five rooms, pharmacy in the building; available for immediate occupancy, adequate parking; near Interstates. Call 356-6087 or 882-0160.

## FAMILY PRACTITIONERS

Excellent opportunity to thrive in a group setting. Premium financial reward. Partnership in one year. Great investment opportunities. Fringe benefits. Healthy active community with good schools located in northwest Indiana. Please contact: W. V. Hehemann, M.D., Department of Family Practice, The Hammond Clinic, 7905 Calumet Avenue, Munster, Ind. 46321.

**WANTED:** County Health Department Director, Northern Indiana. Pop. 126,500. Fast growing. Active generalized program. Paid vacation and holidays. Sick leave. M.D. or D.O. Reply Box 378, The Journal, ISMA, 3935 N. Meridian St., Indianapolis 46208.

**BUY** my large, stately home, ideal for large family, and take over free my annual gross of \$100,000 practice. Ideal for GP with interest in gen. surg., ped. or OB. Excellent hospital, schools, etc. Please call (219) 347-3608.

**INDIANA—INDIANAPOLIS AND SURROUNDING AREA:**  
Emergency Physicians needed. Rapidly growing Professional Corporation that currently has contracts with 2 hospitals needs 4 E.R. Physicians. Choice of living in several small communities or in the City of Indianapolis. Excellent salary, Life Insurance, Professional Liability, Disability Plan, Health Insurance and Comprehensive Pension Plan. Contact Mc Pike Emergency Physicians, Inc., 44 Horseshoe Lane, Carmel, Indiana 46032.

Joseph D. McPike, M.D., President

**FAMILY PRACTICE** opening January 1974 in two-man office. Cashmere, Wash., outstanding orchard community. Scenic area with unlimited recreation opportunities. Partner retiring. Initial salary and early partnership. Edgar A. Meyer, M.D. (Iowa '50) ABFP, 303 Cottage Ave., Cashmere, Wash. 98815 AC509/782-1541

## WANTED

Family practitioners, pediatricians, internists, and obstetricians for dynamic municipal Midwest Health Department providing innovative primary care. Faculty appointment available. Salary \$27,500-\$30,000 negotiable. Must be eligible for Ohio license. Reply P.O. Box 238, Cincinnati, Ohio 45202.

**1973 ROSTERS AND YEARBOOKS** are available. Send check for \$5.00 for the Yearbook (June issue) or \$3.00 for the Roster to: The Journal, 3935 N. Meridian St., Indianapolis 46208.

**GENERAL SURGEON**, Board eligible, married, desires to relocate practice in small town with good hospital, prefer solo, good references, available anytime. Write Box 391, The Journal, 3935 N. Meridian St., Indianapolis 46208.

**WANTED: GENERAL PRACTITIONER.** Good area; good hospital; three months free rent. Write P.O. Box 36067, Oaklandon, Ind. 46236.

**32-YEAR OLD** physician desires partner in active General Practice. Town is located on beautiful lake Maxinkuckee. Practice, though private, is associated with Culver Military Academy. Contact Michael Deery, M.D. Call collect: 219-842-3327.

## NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be consid-

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DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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